



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 20640			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
MYRTLE		A		ADAMS				08		14	79	10:14A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		8. UNDER 24 HRS			
Female		Caucasian		MONTH DAY YEAR		85		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Md.		U S A				Prince Georges County						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Clinton		Southern Maryland Hospital Center		Bureau of engraving		Binder							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		14. STREET ADDRESS					
Md.		Pr. George		Adelphi		YES <input type="checkbox"/> NO <input type="checkbox"/>		10422 Knollwood Drive					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST		FIRST MIDDLE LAST											
Columbus Johnson		Sarah Jenkins											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
NO		577-10-1089D		Francis Adams		Adelphi, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Extensive Aneurysm abdominal aorta rupture</u> 4413 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Coronary Artery Disease</u> (c) <u>Chronic Cholelithiasis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Chronic Renal Failure</u>													
MEDICAL CERTIFICATION													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>8-11</u> , 19 <u>79</u> , to <u>8-14</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>8-14</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
C1020 A MONTAMPT MD		3508 Dodge PK Rd - Lanham MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		Aug 17, 1979		Mt Olivet Cemetery		Washington D C							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
F. Gasch's Sons P A Hyattsville, Md.				AUG 17 1979		[Signature]							

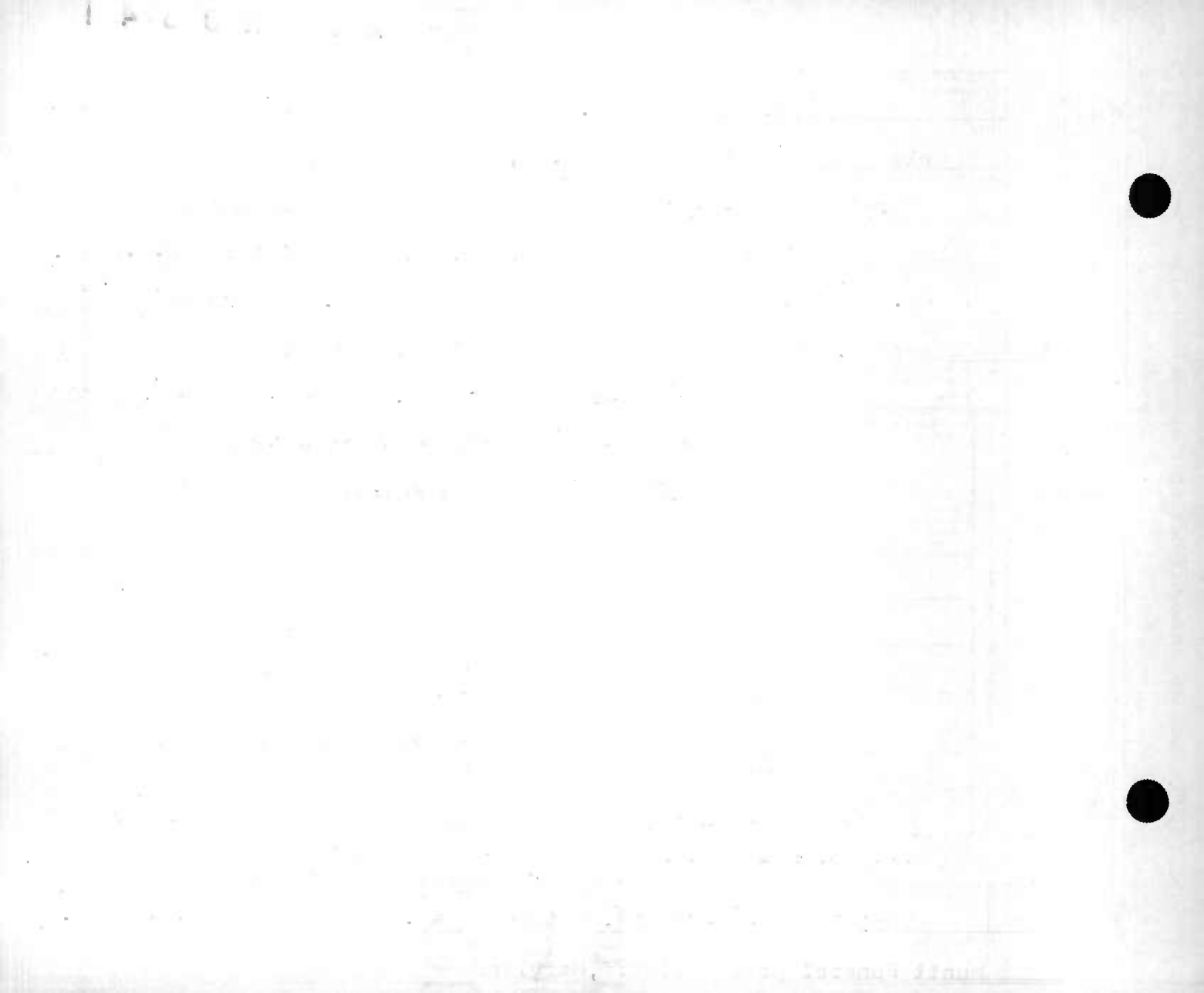
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 0 6 4 1	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Ernest Eugene ALESHIRE Sr.					2a. DATE OF DEATH MONTH DAY YEAR August 24, 1979			2b. HOUR 5:45a.m.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Apr. 5, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.					
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pipe Fitter		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.			
13a. STATE Md.		13b. COUNTY Charles		13c. CITY OR TOWN Waldorf		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. #2 Box 88			
14. FATHER'S NAME FIRST MIDDLE LAST Eugene A. Aleshire					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula V. Southard						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW11		17. INFORMANT ADDRESS Barbara A. Aleshire same as # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Advanced Carcinoma of Hypopharynx 1489 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) with Recalled Aspiration (c) with Recalled Aspiration PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (a) (this hospital) attended the deceased from Aug 1979 to Aug 24 , 19 1979 , that (b) (we) lost saw the deceased alive and above , (c) (we) (did) (did not) view the body after death.											
22b. SIGNATURE BENJAMIN S. PECSON, M.D.					DEGREE		22c. DATE SIGNED 24 Aug. 79		22d. ADDRESS 6106 Old Silver Hill Road District Heights, Maryland 20028		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-28-79		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Md.		24. FUNERAL DIRECTOR NAME ADDRESS Huntt Funeral Home Waldorf, Maryland			
25a. DATE REC'D. BY REGISTRAR AUG 31 1979						25b. REGISTRAR'S SIGNATURE Barbara A. Aleshire					



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR 1. STATE REGISTRAR					7 9 2 0 6 4 2 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IHLA M. ALLEN					2a. DATE OF DEATH MONTH DAY YEAR 08-19-79			2b. HOUR 2:38 P	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 23, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S M. MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4104 Yardley Court	
14. FATHER'S NAME FIRST MIDDLE LAST Hiram Gay					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Sovay				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a		17. INFORMANT ADDRESS Joan Masters Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>cardiopulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF <i>pneumonia</i> <i>auricular fibrillation</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Extensive pressure ulcers, urinary tract infection</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Extensive pressure ulcers, urinary tract infection</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOBIOGRAPHY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (we) attended the deceased from 1972, 19, to 8-19, 1979, that (I) (we) last saw the deceased alive on 8/19/79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Fred Cristofori</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8/19/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Fred C. Cristofori		MD		22e. ADDRESS 5327 Superior Lane Beltsville, MD 20715					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 22 AUG 79		23c. NAME OF CEMETERY OR CREMATORY Sts Peter & Paul Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Marple TNshp, Delaware, Penn.			
24. FUNERAL DIRECTOR NAME Robert G. Beall Funeral Home 9013 Annapolis Rd. Lanham, Md. 20801				25a. DATE REC'D. BY REGISTRAR AUG 24 1979		25b. REGISTRAR'S SIGNATURE <i>Henry K. Brady</i>			

2005

JEL classification: J40; J60; J70; J80; J90; O50; O51; O52; O53; O54; O55; O56; O57; O58; O59; O60; O61; O62; O63; O64; O65; O66; O67; O68; O69; O70; O71; O72; O73; O74; O75; O76; O77; O78; O79; O80; O81; O82; O83; O84; O85; O86; O87; O88; O89; O90; O91; O92; O93; O94; O95; O96; O97; O98; O99

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) GERTRUDE ANDERSON		2a. DATE OF DEATH MONTH 08 DAY 08 YEAR 79		2b. HOUR 12:15	
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH JANUARY DAY 25 YEAR 1930		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE MD.	
10. CITY OR TOWN OF DEATH CHEVERLY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION PRINCE GEORGE GENERAL HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY N/A
13a. STATE MARYLAND		13b. COUNTY P. G.	13c. CITY OR TOWN LARGO	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME RAYMOND L. CARTER		15. MOTHER'S MAIDEN NAME GERTRUDE KING			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 518 38 3611		17. INFORMANT ADDRESS Road, Lanham, MD. SHIRLEY A. CHASE/daughter/3030 Brightseat.	
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiomyopathy 4254 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetic Mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Feb 1, 1978 to August 8, 1979 , that (I) (we) last saw the deceased alive on April 7, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (and not) view the body after death.					
22b. SIGNATURE David M. Goldman		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/8/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David M. Goldman		22e. ADDRESS 6525 Belcrest Rd., Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Aug. 11, 1979		23c. NAME OF CEMETERY OR CREMATORY HARMONY CEMETERY	
23d. LOCATION CITY OR TOWN LANDOVER PG MARYLAND		23e. DATE REC'D. BY REGISTRAR AUG 15 1979			
24. FUNERAL DIRECTOR ROLLINS FUNERAL HOME, INC.		25b. REGISTRAR'S SIGNATURE Anthony McBrady			

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					7 9 20644 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MAY PEARSON Ashby					2a. DATE OF DEATH MONTH DAY YEAR 8 27 79					2b. HOUR 6:15 A M
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 9 13, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 70 years YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges Co. MD.				
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinton Convalescent Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Clerk		12b. KIND OF BUSINESS OR INDUSTRY Gift Shop		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Prince Georges LANHAM					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7017 96th Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST Elliot QUINN GARNER					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian M. COX					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-18-3513		17. INFORMANT ADDRESS Rosalee M. Dethloff, 7017 96th Avenue Lanham, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arrest DUE TO, OR AS A CONSEQUENCE OF Possible Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF days									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Thalate sedation										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 8/21 , 19 79 , to 8/26 , 19 79 , that (I) (we) last saw the deceased alive on 8 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE R. E. Z. MISTAKAN					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/27/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. E. Z. MISTAKAN					22e. ADDRESS 4235 26th Ave Md 20831					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/30/79		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md.				
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A.					25. DATE REC'D. BY REGISTRAR AUG 28 1979		26. REGISTRAR'S SIGNATURE Patricia K. B...			
24. FUNERAL DIRECTOR Hyattsville, Maryland										

MEDICAL CERTIFICATION

72

0405

17

Female

White

P 13 1908

7044

218-18-323

No

Elliot Gann Garner

4.11.1904

M.

Cox

Maryland Insurance Company

1913

1913

Clinton

Clinton

Clinton

Clinton

Clinton

Clinton

Clinton

Clinton

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOU. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										20645 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Edgar Brown BARBOUR						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 8-8 1979		2b. HOUR 10:30 PM			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR November 22/31 57	6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN 21 57	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD 8-8 1979		2d. HOUR 10:30 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Virginia		7b. COUNTRY OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD					
10. CITY OR TOWN OF DEATH Camp Springs		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Malcolm Grow A.A.F.B.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Crane Operator		12b. KIND OF BUSINESS OR INDUSTRY Metro			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Camp Springs		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7106 Eisenhower Ct.			
14. FATHER'S NAME FIRST MIDDLE LAST John Harry Barbour				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie Wright							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) WW11		16b. SOCIAL SECURITY NO. 235-28-3106		17. INFORMANT ADDRESS Virginia W. Barbour Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Certain selective Cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Augusto P. Rodriguez				TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER		DATE SIGNED 8-9-79			
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.				ADDRESS 5009 Rayburn Ct., Camp Springs, Md. 20031							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/13/79		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery Brentwood		23d. LOCATION CITY OR TOWN COUNTY STATE P.G. Maryland					
24. FUNERAL DIRECTOR NAME Lee Funeral Home Inc. ADDRESS 6633 Old Alexander Ferry Rd. Clinton, Md.				25a. DATE RECD. BY REGISTRAR Aug 31 1979		25b. REGISTRAR'S SIGNATURE [Signature]					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1. FOR STATE REGISTRAR			REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST WILSON		MIDDLE HARDEE		LAST BARHAM		2a. DATE OF DEATH MONTH DAY YEAR 08 26 79		2b. HOUR 1:42 A.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR NOV. 1, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.						
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSPITAL						12a. USUAL OCCUPATION (IF NOT WORKING, GIVE MOST OF WORKING LIFE) MACHANIC		12b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED		
13a. STATE MARYLAND			13b. COUNTY PRINCE GEO.		13c. CITY OR TOWN BLADENSBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5301 QUINCY STREET			
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM BARHAM				15. MOTHER'S MAIDEN NAME MIDDLE LAST EDLA MARY Spivey								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 577 05 8034A		17. INFORMANT 6203 Kennedy Street Riverdale, Md. 20840 Eugene Bromley							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> 5939 DUE TO, OR AS A CONSEQUENCE OF <u>CHD = CHF</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>RENAL INSUFFICIENCY</u> (c) <u>RENAL INSUFFICIENCY</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>COPO, DIABETES Mellitus, Cholelithiasis</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>8-13</u> , 19 <u>79</u> , to <u>8-26</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>8-26</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>H. A. Molaw</u> M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED 8/26/79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>H. A. Molaw M.D.</u>			22e. ADDRESS <u>6065 Landover Rd. Cheverly, Md. 20785</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/29/79		23c. NAME OF CEMETERY OR CREMATORY George Washington Cem			23d. LOCATION CITY OR TOWN COUNTY STATE Hyattsville P.G. Md.				
24. FUNERAL DIRECTOR'S NAME <u>Francis Gasch's Sons Funeral Home, P.A.</u> Hyattsville, Maryland					25a. DATE REC'D. BY REGISTRAR AUG 28 1979			25b. REGISTRAR'S SIGNATURE <u>Robert A. Bandy</u>				

C. A. C. S.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7	9	2	0	6	4	7
1- FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) John Francis Beck, Jr.										2a. DATE OF DEATH MONTH DAY YEAR August 2 1979				2b. HOUR 5:30 A.M.		
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Apr 15 1901				6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D. C.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.										
10. CITY OR TOWN OF DEATH District Heights		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6712 Gateway Boulevard						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Service Salesman - Auto		12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Dist. Hgts		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6712 Gateway Boulevard								
14 FATHER'S NAME John Francis Beck, Sr.					15 MOTHER'S MAIDEN NAME Marie Crawford											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-10-4485		17. INFORMANT ADDRESS H. Marie Beck, Wife, Same as Above												
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from <u>1975</u> , 19____, to <u>Aug 2</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Aug 1</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <u>John F. Shay</u> DEGREE										22c. DATE SIGNED 8-3-79						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. John F. Shay										22e. ADDRESS 5509 Silver Hill Rd., Dist. Hgts, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-4-79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G., Maryland										
24 FUNERAL DIRECTOR'S NAME Robt E Wilhelm Funeral Home Rd., Suitland, Md.										25a. DATE REC'D. BY REGISTRAR Aug 7 1979		25b. REGISTRAR'S SIGNATURE <u>L. J. McCreedy</u>				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGES 4 AND 5 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										20648	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Beckenstrater						2a. DATE KNOWN OF DEATH ESTIMATED 8-5-79		2b. HOUR 12		2c. DATE PRONOUNCED DEAD 8-5-79	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 2 DAY 13 YEAR 94		6. AGE (IN YEARS) LAST BIRTHDAY 85 YRS.		IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN.		2d. HOUR 12	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD	
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pr. Geo. Gen. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE Md.				13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Cottage City		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3714 - Parkwood St.	
14. FATHER'S NAME FIRST William MIDDLE J. LAST Wheatley						15. MOTHER'S MAIDEN NAME FIRST Lillian MIDDLE A. LAST Boarman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 220-44-8822		17. INFORMANT ADDRESS Mary L. Smith - above address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 888- Pulmonary thrombosis (Dtr) IMMEDIATE CAUSE (a) Pulmonary thrombosis (Dtr) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Left femoral neck fracture DUE TO, OR AS A CONSEQUENCE OF (c) -										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Hypertensive cardiovascular disease											
19a. DATE OF OPERATION 7/20-79				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Left femoral neck fracture				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH 10:30 P.M. 7/21/79				21b. TIME OF INJURY HOUR 10:30 P.M. MONTH 7 DAY 21 YEAR 79				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fell at home			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK Home				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION STREET 3714 Parkwood Street CITY OR TOWN Cottage City COUNTY Pr. Geo. STATE Md			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> In my opinion											
ACTUAL SIGNATURE August P. Rodriguez				M.D. Reguly				MEDICAL EXAMINER 5009 Rayburn Ch, Chevy Springs			
EXAMINER'S NAME (TYPE OR PRINT) August P. Rodriguez				ADDRESS 5009 Rayburn Ch, Chevy Springs				DATE SIGNED 8-5-79			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8/8/1979		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		23d. LOCATION CITY OR TOWN Wash., D.C. COUNTY Dist. Columbia STATE D.C.			
24. FUNERAL DIRECTOR NAME Nalley's F. J. Inc. ADDRESS Mt. Rainier, Md.				25a. DATE REC'D. BY REGISTRAR AUG 09 1979				25b. REGISTRAR'S SIGNATURE Robert M. Brady			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 79 20649			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bernhard F. BECKER				August 28 1979 4:38 P.M.			
3 SEX male		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR Oct 3, 1914		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 64 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? U S A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Naval Research Lab.		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. STATE Md				13b. COUNTY Pro Georges		13c. CITY OR TOWN Cheverly	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 6320 Inwood Street			
14 FATHER'S NAME FIRST MIDDLE LAST Bernhard George Becker				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Agnes Franklin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 493 09 1469		17 INFORMANT ADDRESS Inez Becker Cheverly, Md			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarct 410- DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 4 year						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I (this hospital) attended the deceased from Oct 3 19 75 , to July 31 19 79 , that (I) (we) lost spw the deceased alive on Aug. 20 19 77 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Thomas M. Hutelma				DEGREE M.D.		22c. DATE SIGNED 8/29/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL Cremation		23b. DATE Aug 30, 1979		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pro Georges Md	
24. FUNERAL DIRECTOR NAME ADDRESS F. Gasch's Sons P A Hyattsville, Md				25a. DATE REC'D. BY REGISTRAR SEP 4 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

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August 31 1943

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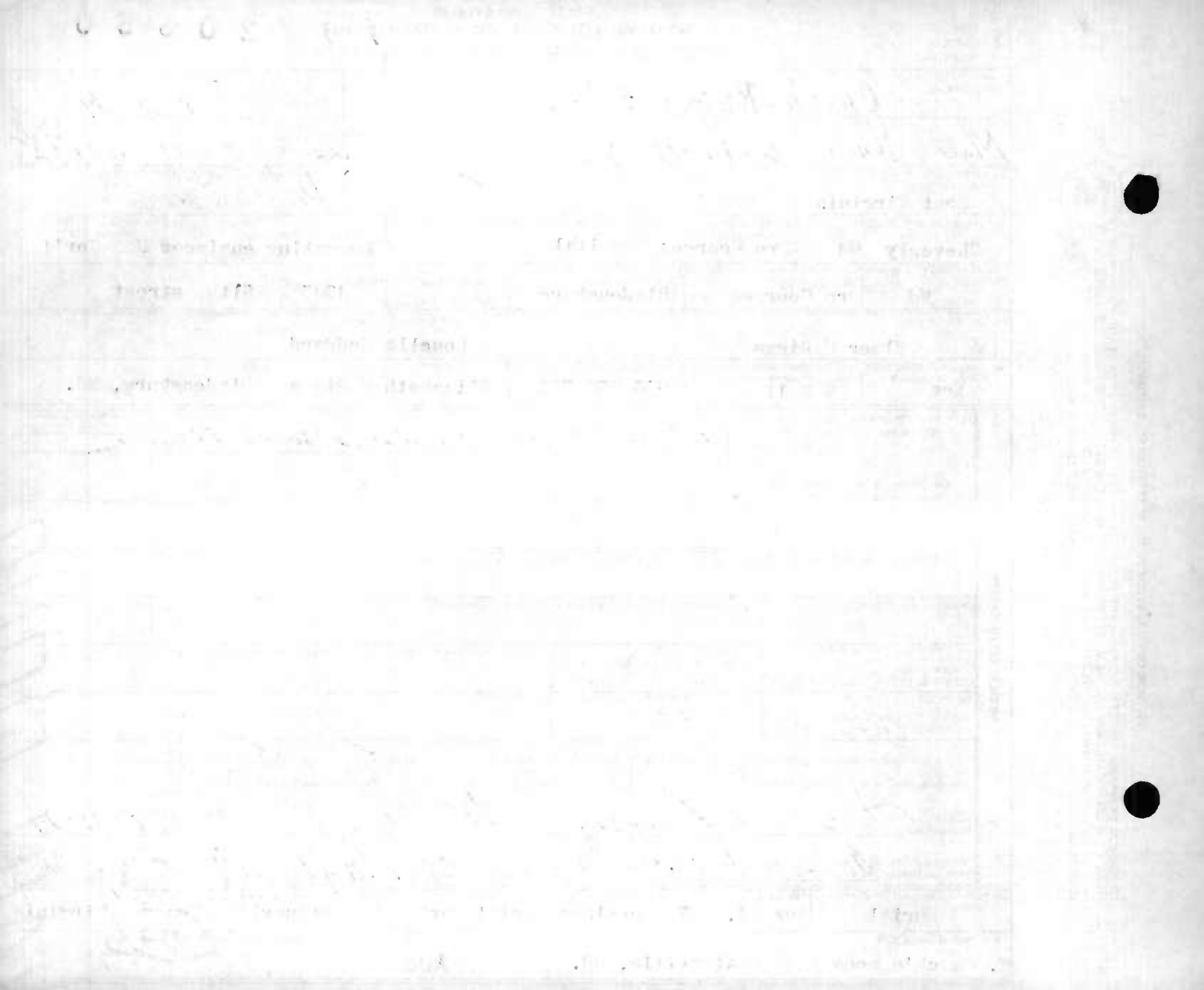
1943

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY OCCURS, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
30M 7/73

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										20650															
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH										2b. HOUR															
Charles REED Biggs										8-11-79										M															
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR		M																			
Male		White		6-15-17		62 YRS.						8-11-79		78		M																			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED				9. BALTIMORE CITY OR COUNTY OF DEATH				MD.																			
West Virginia				U S A				NEVER MARRIED				Primer Georges																							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY																							
Cheverly Md				Pro Georges Hospital				Operating engineer				U S Gov't																							
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS																									
Md				Pro Georges		Bladensburg		YES <input type="checkbox"/> NO <input type="checkbox"/>		4305		51th street																							
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME																													
Elmer H Biggs						Louella Goddard																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS																							
Yes						236 056 332						Elizabeth H Biggs Bladensburg, Md.																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																					
PART 1 DEATH WAS CAUSED BY:																																			
IMMEDIATE CAUSE (a)																																			
4292																																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																																			
DUE TO, OR AS A CONSEQUENCE OF																																			
(b)																																			
DUE TO, OR AS A CONSEQUENCE OF																																			
(c)																																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?																							
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE																							
22. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																																			
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED															
Augusto P. Rodriguez										Deputy										8-11-79															
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																									
Augusto P. Rodriguez										5009 Rayburn Court, Camp Springs																									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION CITY OR TOWN COUNTY STATE																	
Burial						Aug 14, 1979						Roselawn Burial Park						Martinsville Henry Virginia																	
24. FUNERAL DIRECTOR NAME												25a. DATE REC'D. BY REGISTRAR												25b. REGISTRAR'S SIGNATURE											
T. Gasch's Sons P A Hyattsville, Md.												AUG 16 1979												Hickory McCreedy											



Items 8, 7 8555 9/21/79 gJ STATE OF MARYLAND
 1- STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 REGISTRAR CERTIFICATE OF DEATH

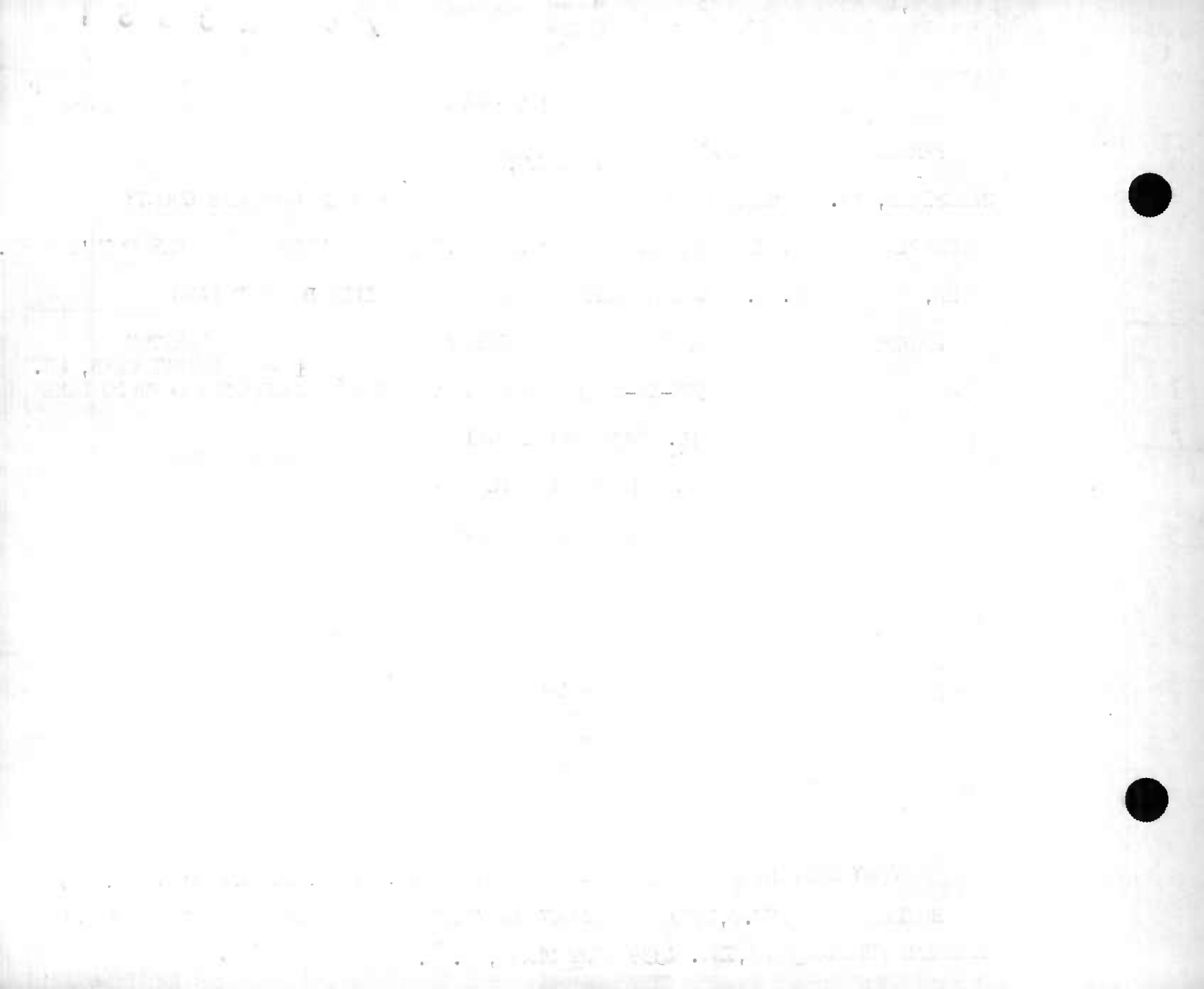
REG. NO. 7 9 2 0 6 5 1

1. DECEASED NAME (TYPE OR PRINT) ROSA BIRT WEAVER			2a. DATE OF DEATH MONTH 08 DAY 02 YEAR 79			2b. HOUR 3:00		P M	
3 SEX FEMALE		4 RACE BLACK		5 DATE OF BIRTH MONTH JULY DAY 27 YEAR 1918		6 AGE (IN YEARS LAST BIRTHDAY) 61 YRS		7 UNDER 1 YEAR MONTHS 00 DAYS 00	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WAKEFIELD, VA.		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.			
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSE		12b. KIND OF BUSINESS OR INDUSTRY FREEDMEN'S HOSP.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD, 13b. COUNTY P. G. 13c. CITY OR TOWN CHAPEL OAKS			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1213 DOEWOOD LANE				
14 FATHER'S NAME FIRST JOSEPH MIDDLE BIRT LAST WEAVER				15 MOTHER'S MAIDEN NAME FIRST VINNEY MIDDLE HAMPTON LAST WEAVER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-12-2893		17 INFORMANT Name Friend ADDRESS CHAPEL OAKS, MD. LAWRENCE WEAVER/HUSBAND/1213 DOEWOOD LANE					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BIL. PULMONARY EMBOLI 5900 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF CHRONIC RENAL FAILURE (c) DUE TO, OR AS A CONSEQUENCE OF CHRONIC PYELONEPHRITIS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5-4 19 79 , to 8-2 19 79 , that (I) (we) last saw the deceased alive on 8-1 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Barry Epstein</i>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-3-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY EPSTEIN						22e. ADDRESS 6201 GREENBELT RD. COLLEGE PARK MD. 20740			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE AUG. 8, 1979		23c. NAME OF CEMETERY OR CREMATORY HARMONY CEMETERY		23d. LOCATION CITY OR TOWN LANDOVER COUNTY PG STATE MARYLAND		
24 FUNERAL DIRECTOR ROLLINS FUNERAL HOME, INC.						25a. DATE REC'D. BY REGISTRAR E. AUG 7 1979		25b. REGISTRAR'S SIGNATURE <i>Barry Epstein</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

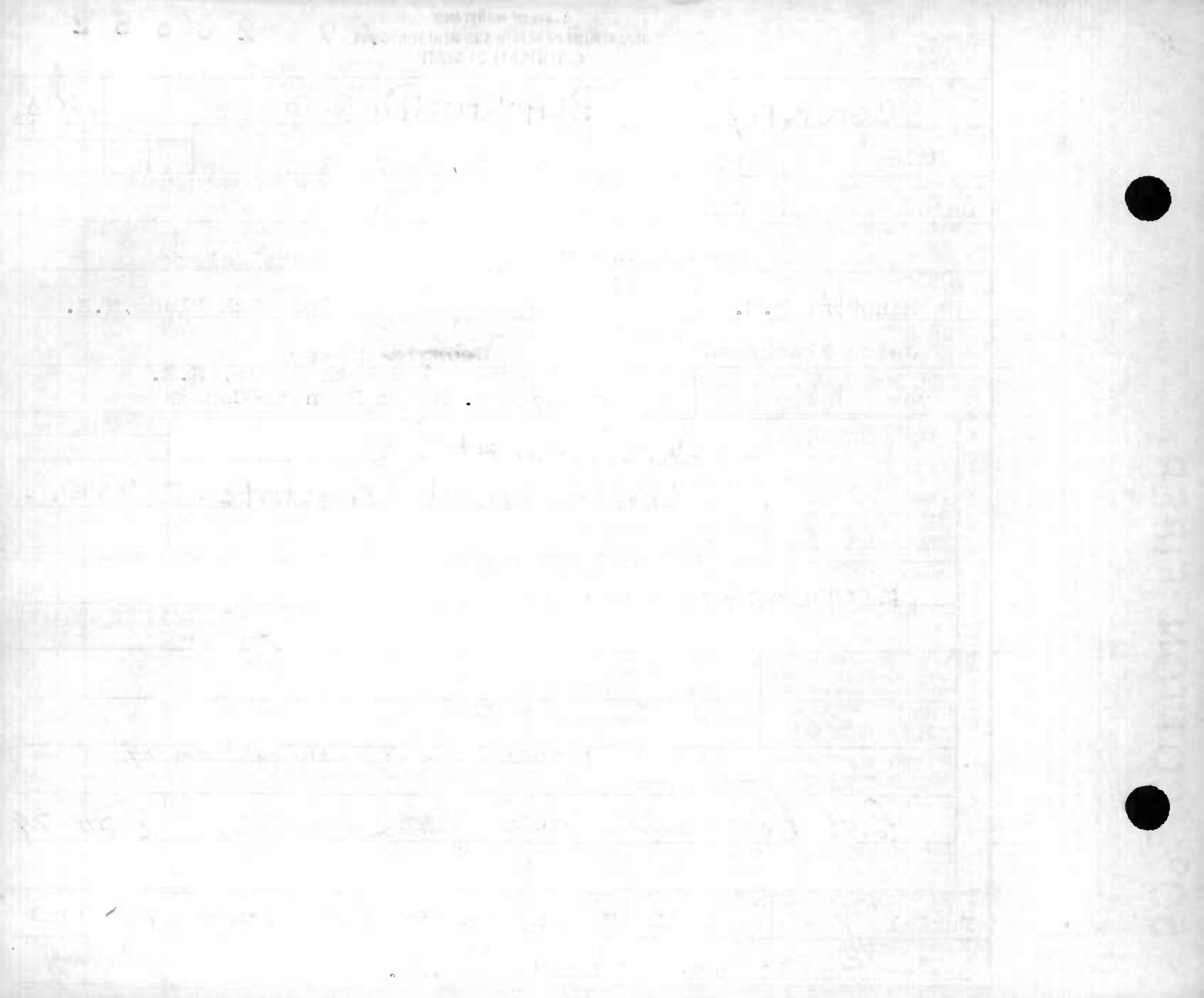


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 0 6 5 2					
1. FOR STATE REGISTRAR			REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2b. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
CONWAY							BLACKFORD		8-20-79					12:15 AM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. # UNDER 1 YEAR		8. IF UNDER 24 HRS.	
Male			Black			May 18, 1907			72 YRS.			MONTHS		DAYS	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			9b. CITIZEN OF WHAT COUNTRY?			10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					MD	
Ohio			USA						R.S.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
			Grooms Rest Home						Postal clerk						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
13a. STATE										YES <input type="checkbox"/> NO <input type="checkbox"/>		105 49th Place, N.E.			
13b. COUNTY															
13c. CITY OR TOWN															
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME										
FIRST					FIRST					MIDDLE					
Jesse Blackford					Georgia Conway										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT					
Yes					092 01 4975					105 49th Place, N.E. Mrs. Alice Barnett-Cousin					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 185- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of Prostate.</u> 24 YRS DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Broncho pneumonia</u>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> 19 <u>78</u> , to <u>August 20</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>8-19-</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (h) (we) (did) (did not) view the body after death.										22b. SIGNATURE <u>L.H. Coleman</u> DEGREE <u>MD</u>		22c. DATE SIGNED <u>8-20-79</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial			8/24/79		Harmony Memorial Park			Landover, Maryland							
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
Stewart Funeral Home-4001 Benning Road, NE			AUG 27 1979			notary, the body									

BP

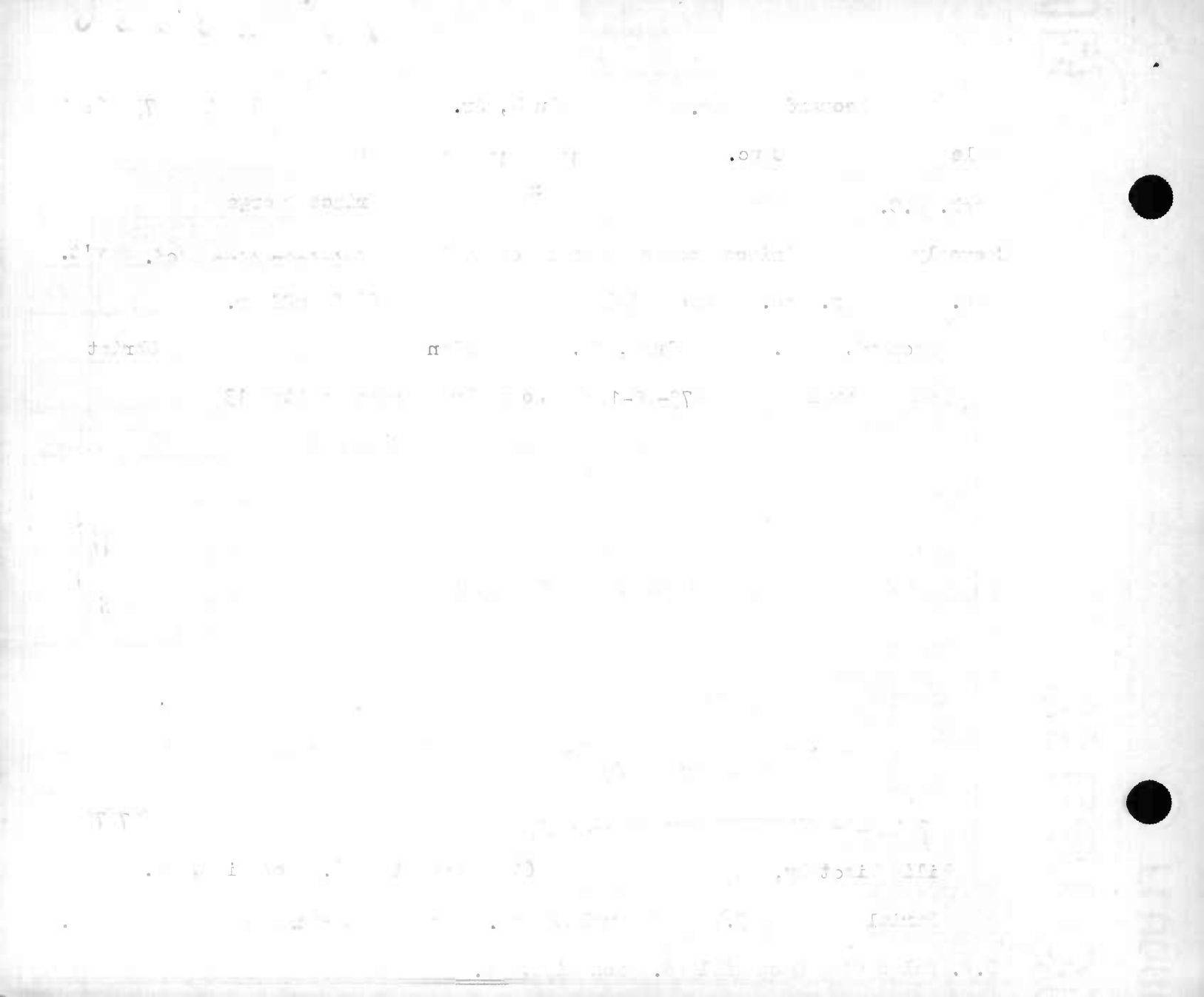


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR			REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Leonard A. Blush, Jr.			2a. DATE OF DEATH MONTH 8 DAY 25 YEAR 79			2b. HOUR 6:03p M				
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH 12 DAY 12 YEAR 24		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.				
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrative		12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't.		
13a. STATE Md.			13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Oxon Hill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6602 Huff Dr.	
14. FATHER'S NAME FIRST Leonard. MIDDLE A. LAST Blush, Sr.			15. MOTHER'S MAIDEN NAME FIRST Helen MIDDLE LAST Christ							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO WWII		17. INFORMANT ADDRESS Joan Blush same as item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY ARTERY DISEASE 4149 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YEARS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CONGESTIVE HEART FAILURE										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED [ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2]					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from JAN 19 79 , to AUG 19 79 , that (I) was last saw the deceased alive on AUG 24 19 79 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE P. W.			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/27/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Philip Wisotsky, MD			22e. ADDRESS 6188 Oxon Hill Rd. Oxon Hill, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/29/79		23c. NAME OF CEMETERY OR CREMATORY Maryland Vet. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham Md.			
24. FUNERAL DIRECTOR NAME G.P. Kalas			ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.			25a. DATE REC'D. BY REGISTRAR AUG 29 1979		25b. REGISTRAR'S SIGNATURE Patricia McCready		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 7/77
(VR A 15 (4))

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		7 9 20654 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) EDYTHE A BOOKER		2a. DATE OF DEATH MONTH DAY YEAR 08 16 79		2b. HOUR P 4:20 M	
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 12-18-1911		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7c. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE MD.		13b. COUNTY P.G.		13c. CITY OR TOWN BEAT REASANT	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM SCOTT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH KING		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 579-16-3687		17. INFORMANT HENRY O. BOOKER - SAME AS #13 ABOVE		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple organ failure 7999 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION 8/8/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from 8-24, 19 79, to 8-10, 19 79, that (I) (we) lost saw the deceased alive on 8-14 79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Dr. Hong	
22c. DEGREE MD		22d. DATE SIGNED 8/17/79		22e. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22f. PHYSICIAN'S NAME (TYPE OR PRINT) NGANG THONG LIN PHUONG THAP		22g. ADDRESS C.C. Hospital Cheverly, MD		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	
23b. DATE 8-20-79		23c. NAME OF CEMETERY OR CREMATORY LINCOLN MEM. CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND, P.G. MD.	
24. FUNERAL DIRECTOR NAME H.S. WASHINGTON - SONS		ADDRESS 4925 Burroughs Ave		25a. DATE REC'D. BY REGISTRAR AUG 28 1979	
25b. REGISTRAR'S SIGNATURE Henry O. Booker					

Washington

11-11-3000

STANDARD FORM NO. 64

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PRINCE GEORGE'S COUNTY

W. J. F.

PRINCE GEORGE'S GENERAL HOSPITAL

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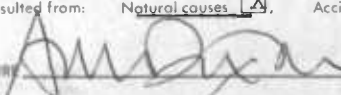
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AUG 8 1979

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH20655
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST SHANE			MIDDLE PATRICK			LAST BORUM			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 8 1 1979			2b. HOUR M 11:59 p M				
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR July 2, 1979		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 1 YRS.		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 1 1979			2d. HOUR p M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md				7b. CITIZEN OF WHAT COUNTRY? U S A				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.							
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Gen. Hosp. (DOA)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md				13b. COUNTY Pro Georges		13c. CITY OR TOWN Bladensburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5453 Madison Way									
14. FATHER'S NAME FIRST MIDDLE LAST Donald J Borum								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Deborah Tucker											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None				17. INFORMANT Donald J Borum				ADDRESS Bladensburg, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome 7980 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE 				M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 8-2-79							
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Aug 4, 1979		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pro Georges Md.									
24. FUNERAL DIRECTOR NAME F. Gasch's Sons P A				ADDRESS Hyattsville, Md.				25a. DATE RECD. BY REGISTRY Aug 6 1979				REGISTRY Prince Georges County							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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THE UNITED STATES OF AMERICA
DEPARTMENT OF THE ARMY
OFFICE OF THE CHIEF OF STAFF

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

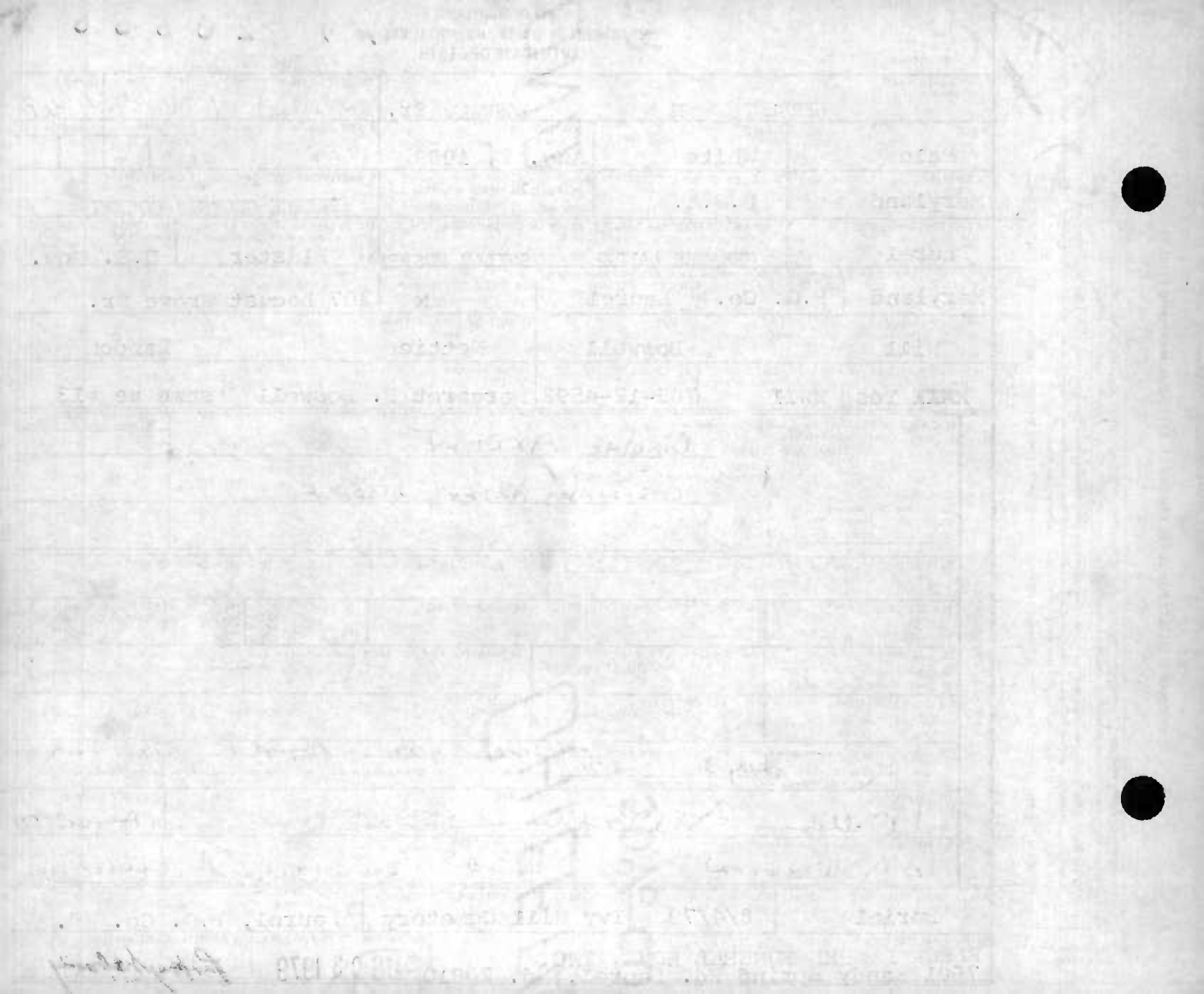
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HERBERT M BOSWELL Sr.			2a. DATE OF DEATH MONTH DAY YEAR August 1 1979			2b. HOUR 4:30 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 2, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.		
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER LAUREL BELTSVILLE HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plaster		
12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.		13a. STATE Maryland		13b. COUNTY P.G. Co.		13c. CITY OR TOWN Laurel		
14. FATHER'S NAME FIRST MIDDLE LAST Will Boswell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie Landon		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 207 Locust Grove Dr.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) XXXX Yes		(IF YES, GIVE WAR OR DATES) WWII		16b. SOCIAL SECURITY NO. 705-12-4592		17. INFORMANT ADDRESS Margaret F. Boswell same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> 4149 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CORONARY ARTERY DISEASE</u> (c) } DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from <u>February</u> , 19 <u>79</u> , to <u>August 1</u> , 19 <u>79</u> , that (1) (he) last saw the deceased alive on <u>July 31</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>William A. Warren</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1 August 1979		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W.A. Warren				22e. ADDRESS 301 Prince George St Laurel, Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/4/79		23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, P.G. Co. Md.		
24. FUNERAL DIRECTOR FLECK LAUREL FUNERAL HOME, INC. 7601 Sandy Spring Rd. Laurel, Md. 20810				25a. DATE REC'D. BY REGISTRAR AUG 03 1979		25b. REGISTRAR'S SIGNATURE <u>Esther Labandy</u>		



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20657

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Sarah Webb Bozzi			2a DATE OF DEATH MONTH DAY YEAR 8 17 79		2b HOUR 5:39a	
3 SEX F		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 01 19 95		
6 AGE (IN YEARS LAST BIRTHDAY) 84		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vermont		7b CITIZEN OF WHAT COUNTRY? USA		
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince George MD				
10 CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md. Hospital Cntr.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
13a STATE Md.		13b COUNTY P.G.		13c CITY OR TOWN Forestville		
14 FATHER'S NAME FIRST MIDDLE LAST William Moroney		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Exilda LaFarmen				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 213-74-9884		17 INFORMANT 2504 Senator Avenue Albert Bozzi, Son Dist, Hgts, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypostatic Pneumonia 2252 DUE TO, OR AS A CONSEQUENCE OF (b) Stroke Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Meningioma tumor of Brain APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks. 2 months ± 1 year.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Congestive Heart Failure.						
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from 4-3 19 72 to 8/16 19 79 , that (I) (we) last saw the deceased alive on 8/16 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE Richard Alan Farson, M.D., P.A.				22c DATE SIGNED 8-17-79		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Richard Alan Farson				22e ADDRESS 9401 Indian Head Highway Suite 360 Oxon Hill, MD 20022		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 8-21-79		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		
23d LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G., Md.		24 FUNERAL DIRECTOR NAME Robt E Wilhelm		25a DATE REC'D. BY REGISTRAR AUG 22 1979		
25b REGISTRAR'S SIGNATURE Richard Alan Farson		25c REGISTRAR'S SIGNATURE Richard Alan Farson				

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

511100 Southern Bell Hospital Ctr.

A 62-47-210

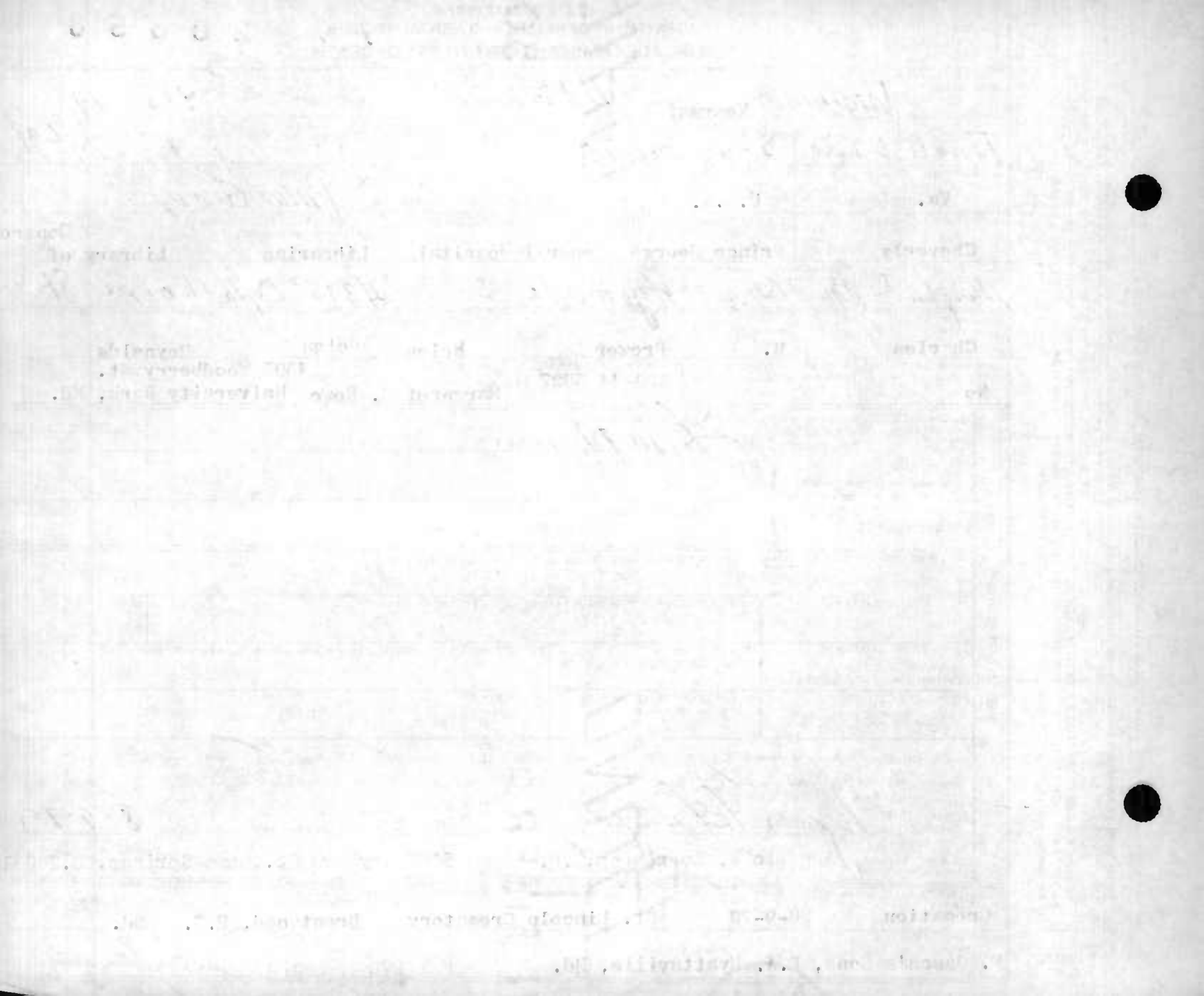
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

20658

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Virginia Wemyss BREWER		2a. DATE KNOWN OF DEATH ESTI- MATED 8-8 1979		2b. HOUR 6:30
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2-20-04 75	6. AGE (IN YEARS (LAST BIRTHDAY) 75 YRS.	7. DATE PRONOUNCED DEAD 8-8 1979
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
11. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Librarian
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Librarian		12b. KIND OF BUSINESS OR INDUSTRY Library of Congress
13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS 4315 Eglethorpe St		
14. FATHER'S NAME FIRST MIDDLE LAST Charles B. Brewer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Reynolds		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 220 44 5827		17. INFORMANT Margaret G. Rowe ADDRESS 4303 Woodberry St. University Park, Md.
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leukemia DUE TO, OR AS A CONSEQUENCE OF 2028 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE Augusto P. Rodriguez, M.D.		TITLE (SPECIFY) Deputy MEDICAL EXAMINER		DATE SIGNED 8-9-79
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.		ADDRESS 5009 Rayburn Ct., Camp Springs, Md. 20031		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 8-9-79	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G. Md.	
24. FUNERAL DIRECTOR NAME F. Gasch's Sons, P.A. Hyattsville, Md.		25a. DATE REC'D. BY REGISTRAR AUG 13 1979		25b. REGISTRAR'S SIGNATURE Lantry McLeod



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

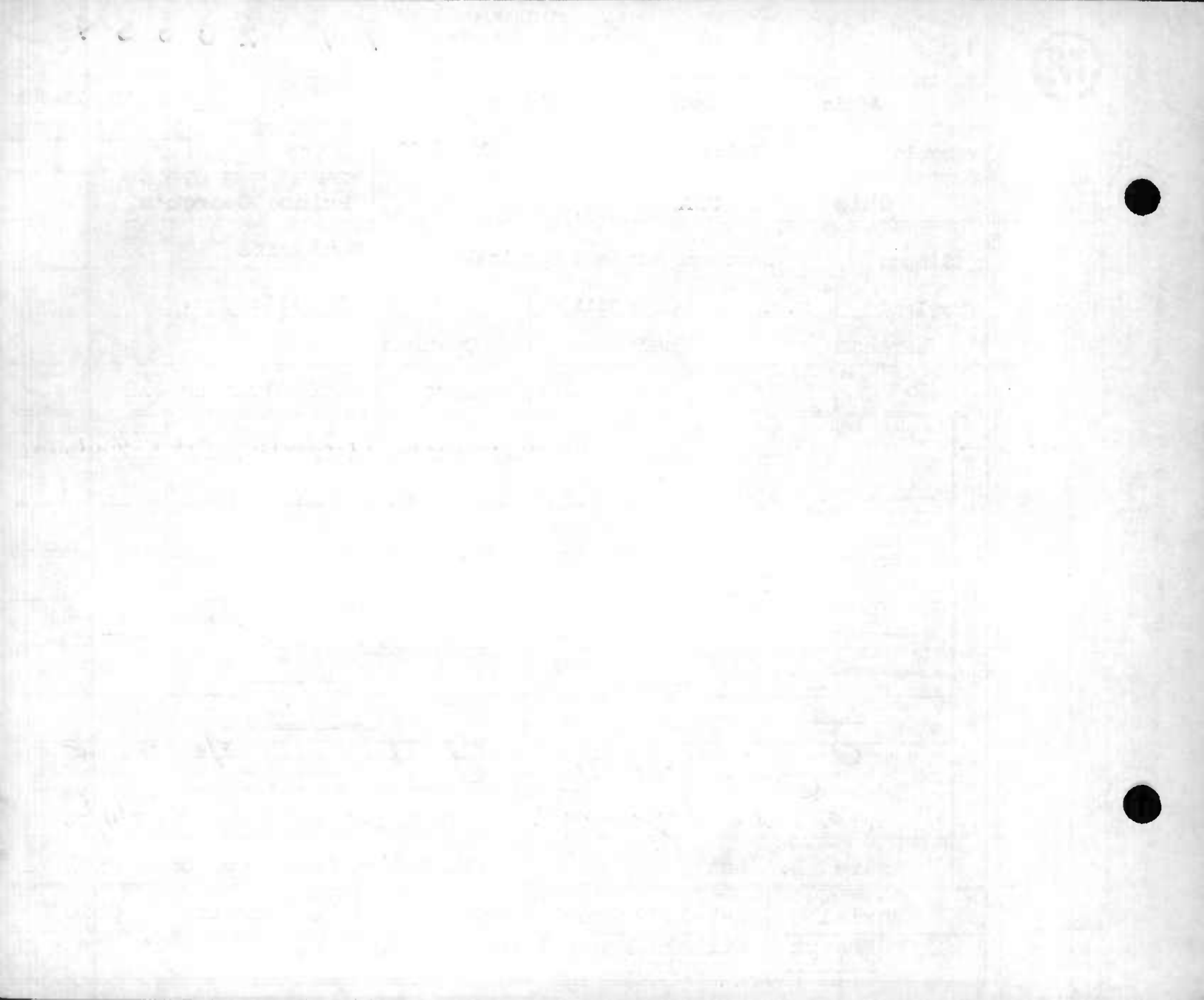
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20659

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Addie Noel Brisker			2a. DATE OF DEATH MONTH 8 DAY 4 YEAR 79		2b. HOUR 11:40A M
3. SEX Female	4. RACE White	5. DATE OF BIRTH APR 31 - 1877	6. AGE (IN YEARS LAST BIRTHDAY) 102 YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.		
10. CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland	13b. COUNTY P.G.	13c. CITY OR TOWN Oxon Hill	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 2168 Alice Ave.	
14. FATHER'S NAME FIRST Abraham MIDDLE Noel LAST		15. MOTHER'S MAIDEN NAME FIRST Cynthia MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) NO		16b. SOCIAL SECURITY NO. 302 03 4839		17. INFORMANT ADDRESS Geneva M Flaff Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Thrombosis. 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 weeks.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Anemia.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/6, 1979 to 8/4, 1979 , that (I) (we) last saw the deceased alive on 8/4, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Andre L. Laz		DEGREE M.O.		22c. DATE SIGNED 8/4/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Andre L. Laz		22e. ADDRESS 9401 Indian Head Hwy Oxon Hill Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-7-1979	23c. NAME OF CEMETERY OR CREMATORY Wheelerburg Cem	23d. LOCATION CITY OR TOWN COUNTY STATE Wheelerburg Ohio		
24. FUNERAL DIRECTOR'S NAME Robert E Wilhelm		ADDRESS Suitland Maryland		25a. DATE RECEIVED BY REGISTRAR AUG 7 1979	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 2 0 6 6 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HOWARD J. BROOKS				2a. DATE OF DEATH MONTH DAY YEAR 08 18 79		2b. HOUR 1:00 PM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Dec. 2, 1908		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN 70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Upholsterer		12b. KIND OF BUSINESS OR INDUSTRY Furniture	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Hyattsville	
14. FATHER'S NAME FIRST MIDDLE LAST George Leonard Brooks				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olive Lee Whittaker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a		17. INFORMANT Ada B. Brooks		ADDRESS Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic Shock 4/40 DUE TO, OR AS A CONSEQUENCE OF (b) atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pulmonary embolus Gastric Bleeding							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from July 19 79 to 18 Aug 19 79 , that (I) (we) last saw the deceased alive on 18 Aug 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.							
22b. SIGNATURE Gerard A. Sweeney, M.D.				DEGREE M.D.		22c. DATE SIGNED 8-18-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gerard A. Sweeney, M.D.				22e. ADDRESS Cheverly, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 20 AUG 79		23c. NAME OF CEMETERY OR CREMATORY Old Farnham Church Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Farnham, Virginia	
24. FUNERAL DIRECTOR NAME Robert G. Beall Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR AUG 22 1979			
25b. REGISTRAR'S SIGNATURE Robert G. Beall				25c. REGISTRAR'S SIGNATURE Robert G. Beall			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "PM". RETAIN PAGE 5 FOR YOUR FILES. GIVE PAGE 6 TO THE FUNERAL DIRECTOR. PAGE 7 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										20661	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Joseph James Brosnahan Jr							2a. DATE KNOWN OF DEATH ESTIMATED 8-19-79		2b. HOUR AM		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 1-4-06	6. AGE (IN YEARS) LAST BIRTHDAY 73 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. MIN	7c. DATE PRONOUNCED DEAD 8-19-79	24 HOUR 6:30 PM				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.					
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sheet Metal Worker		12b. KIND OF BUSINESS OR INDUSTRY Construction			
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE, COUNTY, CITY OR TOWN Maryland Prince Georges Hyattsville							13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3400 38th Avenue		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph J. Brosnahan Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara E. Mead							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 11		17. INFORMANT Joseph B. Brosnahan				ADDRESS Same as #13 (Son)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Augusto P. Rodriguez			TITLE (SPECIFY) M.D.			MEDICAL EXAMINER Augusto P. Rodriguez			DATE SIGNED 8-19-79		
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez			ADDRESS 5009 Rayburn Court, Chevy Chase Md 20815								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/23/79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Md.			
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A.						25a. DATE REC'D. BY REGISTRAR AUG 22 1979			25b. REGISTRAR'S SIGNATURE Anthony McCready		
26. ADDRESS Hyattsville, Maryland											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 1/75
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20662

1. FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) CHARLES Robert BROUGHMAN		2a DATE OF DEATH MONTH 08 DAY 06 YEAR 79 2b HOUR 11:10P.M.	
3 SEX Male	4 RACE Caucasian	5 DATE OF BIRTH MONTH 02 DAY 29 YEAR 24	6 AGE (IN YEARS LAST BIRTHDAY) 55 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D C	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD
10 CITY OR TOWN OF DEATH Clinton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center	12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD. 13b COUNTY Pr. Georges 13c CITY OR TOWN Hillcrest Hgts. 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	12b KIND OF BUSINESS OR INDUSTRY C & P Telephone
14 FATHER'S NAME FIRST Charles MIDDLE R. LAST Broughman		15 MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Margaret LAST Gillin	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b SOCIAL SECURITY NO. 216-16-3729	17 INFORMANT Ann C. Broughman (Wife) ADDRESS As in item 13a	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF LUNG 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____			
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6-26, 1979 to 8-6, 1979 , that (I) (we) lost saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE George H. Nachson	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 7-7-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George H. Nachson		22e. ADDRESS 5620 St. Barnabas Rd., Oxon Hill	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-10-1979	23c. NAME OF CEMETERY OR CREMATORY New Cathedral	23d. LOCATION CITY OR TOWN Baltimore COUNTY Maryland STATE
24 FUNERAL DIRECTOR NAME P. Kalas ADDRESS 6160 Oxon Hill Rd., Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR AUG 10 1979 REGISTRAR'S SIGNATURE P. Kalas	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 20663							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BEDFORD BROWN					2a. DATE OF DEATH MONTH DAY YEAR (AUGUST) 08 08 79		2b. HOUR P M 9:30 A		
3 SEX MALE		4 RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR Jan 3, 1905		6. AGE (IN YEARS LAST BIRTHDAY) YRS 74		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Seat Pl.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 704 Quarry Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Glenn Brown					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA MAE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 237 70 2910		17. INFORMANT ADDRESS Willie H. Brown, son-3216 Pope St., S.E. D.C.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal Bleeding 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Undifferentiated Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs 3 months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) this hospital attended the deceased from 6/26/79 , 19____, to 8/9/79 , 19____, that (b) I saw the deceased alive on 8/8/79 , 19____, and that in my opinion death occurred on the date and hour and from the causes stated above. (c) I did not view the body after death.									
22b. SIGNATURE Adam Billetus				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 8/9/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Adam Billet				22e. ADDRESS Prince Georges General Hosp.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 8/10/79		23c. NAME OF CEMETERY OR CREMATORY Fulton Funeral Home		23d. LOCATION CITY OR TOWN COUNTY STATE Yanceyville, North Carolina			
24. FUNERAL DIRECTOR NAME Alex S. Pope				ADDRESS 2617 Pa Avenue, S.E. DC20020		25a. DATE REC'D. BY REGISTRAR AUG 15 1979		25b. REGISTRAR'S SIGNATURE Jeffrey McBrady	

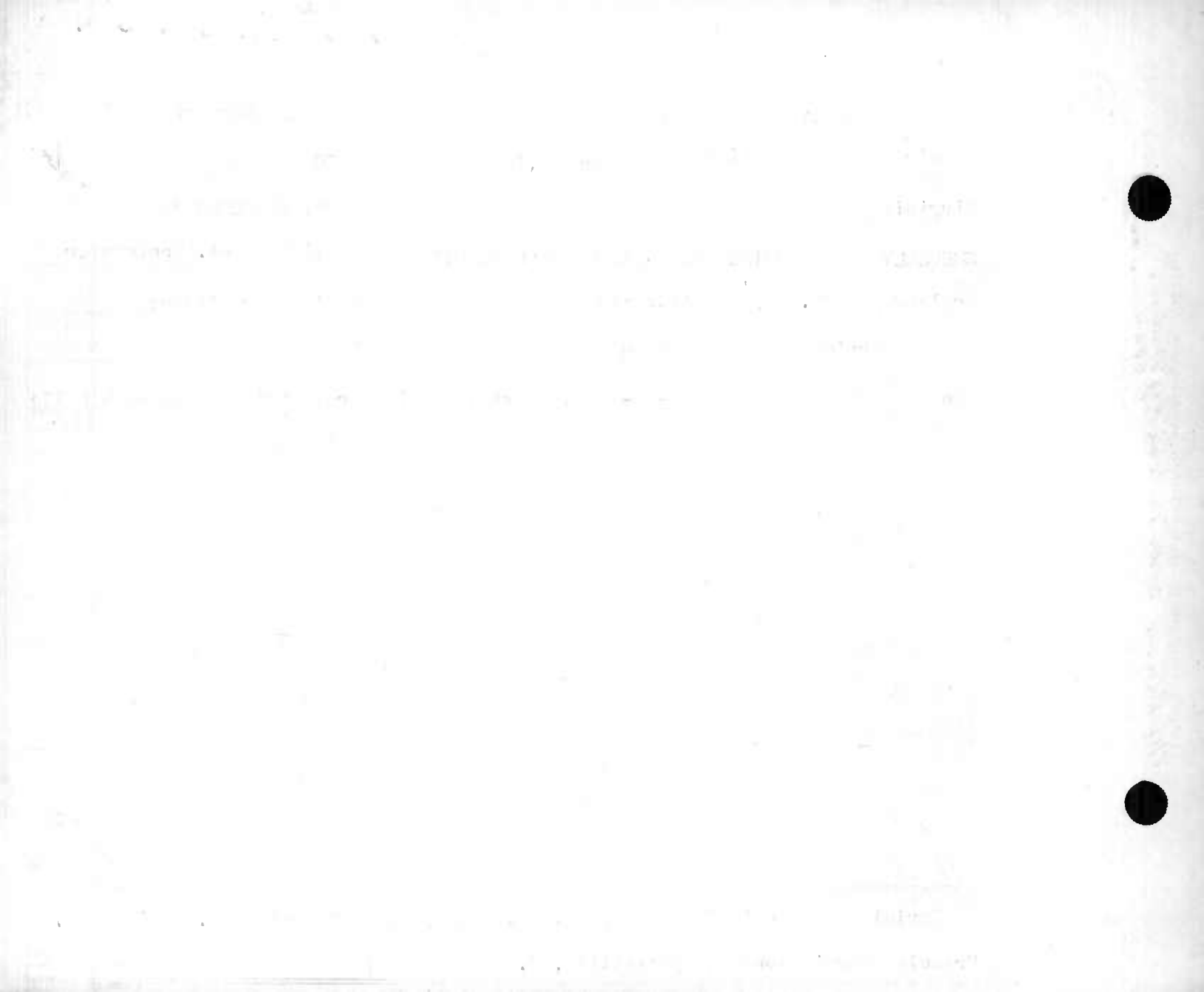
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR 1 - STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRY W. BROWN					2a. DATE OF DEATH MONTH DAY YEAR 08-09-79			2b. HOUR 10:00 AM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec 29, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.				
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter Ret.		12b. KIND OF BUSINESS OR INDUSTRY Contractor		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Pr. Geo's		13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Irving Brown					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 225-05-3770		17. INFORMANT ADDRESS Martha Lillian Brown (wife) same as blk 13e						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHF, Cardiac arrhythmia 4029 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD, advanced Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) HCVD PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Senility										
MEDICAL CERTIFICATION										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 1976 to 8-9-79, that (I) (we) last saw the deceased alive on 8-9-79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE H. A. Molavi, M.D.					DEGREE M.D.			22c. DATE SIGNED 8.10.79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. A. Molavi, M.D.					22e. ADDRESS 6005 Lundover Rd Cheverly, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/11/79		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo's Md.				
24. FUNERAL DIRECTOR NAME Francis Gasch's Sons PA Hyattsville, Md.					25a. DATE REC'D. BY REGISTRAR AUG 14 1979		25b. REGISTRAR'S SIGNATURE H. A. Molavi			



MEDICAL EXAMINER NOTIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
James		Brown						August 31, 1979		12:22A	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		Black		Mar. 27, 1938		46					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Wash., D.C.		USA				Prince Georges MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Landover, Maryland		2314 Brightseat Road				Truck foreman					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Landover						2314 Brightseat Road			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
James T. Brown				Minnie Bailey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
yes		578 42 1257		DeLois Brown-wife-same as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes Mellitus</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>July 1</u> , 19 <u>77</u> , to <u>8-30</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>8-17</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		22c. DATE SIGNED			
								8-31/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
Ciro D. Montoya						3308 Dodge PK Rd Landover					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		9/5/79		Harmony Memorial Park		Landover, Maryland					
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Stewart Funeral Home-4001 Benning Road NE						SEP 6 1979		Linton			

-continued

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20666

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JENNIE ELIZABETH BRUNNER			2a. DATE OF DEATH MONTH 8 DAY 4 YEAR 79			2b. HOUR 4:00 M	
3 SEX FEMALE		4 RACE CAUCASIAN		5. DATE OF BIRTH MONTH 12 DAY 28 YEAR 1896		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.	
10 CITY OR TOWN OF DEATH CLINTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 50 MD HOSPITAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	
13a. STATE MD		13b. COUNTY Pr. George's		13c. CITY OR TOWN CAMP SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST George MIDDLE Shoemaker LAST Shoemaker		15 MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE Garne LAST Garne		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 578-12-9458		17 INFORMANT ADDRESS 4916 Taft Rd Mildred E. Peck, Camp Springs Md					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Heart Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE R.A. McConaughy		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/5/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.A. McConaughy		22e. ADDRESS 5618 St. Barnabas Rd. Oxon Hill, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/7/79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. George Md.	
24 FUNERAL DIRECTOR NAME George P. Kalas ADDRESS Oxon Hill, Maryland				25a. DATE REC'D. BY REGISTRAR AUG 08 1979		25b. REGISTRAR'S SIGNATURE Lester Kalas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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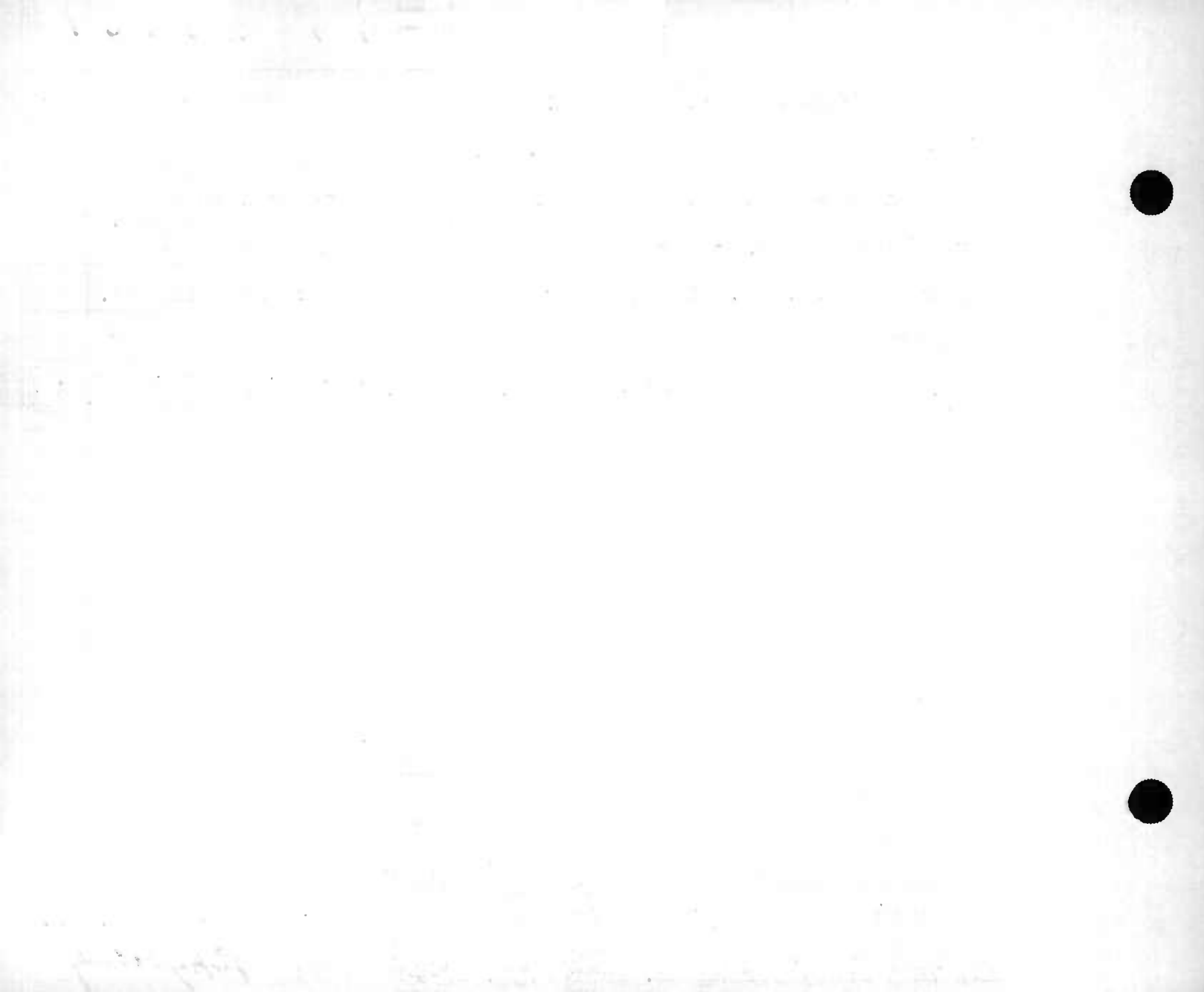


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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				9 20667			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST Mellie W. Bull				MONTH DAY YEAR 8 12 79			
3. SEX FEMALE				2b. HOUR 8-50 AM			
4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Sept. 8, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.			
10. CITY OR TOWN OF DEATH Greenbelt		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greenbelt Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY P.G. Co.		13c. CITY OR TOWN College Park	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Ward				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Stark			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 101-12-9345		17. INFORMANT ADDRESS Mr. Ward C. Bull 4915 Harford Ave. 705 Beltsville, Md. 20705			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> 4/40 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic obstructive pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic pyelonephritis</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u> <u>Several years</u> <u>Several years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>19 72</u> to <u>Aug 12 19 79</u> , that (I) (we) last saw the deceased alive on <u>4-18-19 79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>A. Hussain</u>				DEGREE MD		22c. DATE SIGNED 8-12-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AZHER HUSSAIN M.D.				22e. ADDRESS 4917, Edgewood Road Chevy Chase MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/14/79		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Burtonsville, Mont. Md.	
24. FUNERAL DIRECTOR FLECK LAUREL FUNERAL HOME, INC. 7601 Sandy Spring Rd. Laurel, Md. 20646				25a. DATE REC'D. BY REGISTRAR AUG 13 1979		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 2 0 6 6 8	
1 - FOR STATE REGISTRAR		REG. NO.									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Janet M. ARLE Bunch						2a. DATE OF DEATH MONTH DAY YEAR Aug. 27 79		2b. HOUR 12:03 AM			
3. SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR JULY 14, 1935		6 AGE (IN YEARS LAST BIRTHDAY) 44 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.					
10 CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Eugene Leland Memorial				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PAYROLL CLERK		12b. KIND OF BUSINESS OR INDUSTRY AUTO. CO.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE VIRGINIA						13b COUNTY Westmoreland		13c CITY OR TOWN COLONIAL BEACH			
14. FATHER'S NAME FIRST MIDDLE LAST JOHN I. MEUSHAW						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVELYN WOLF					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217 30 0408		17. INFORMANT ADDRESS Frederick C. Bunch Same as #13 (Husband)							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest secondary to arrhythmia 586- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Renal failure									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours 3 weeks 3 weeks		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Diabetes mellitus											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from August 19, 1968 , to August 27, 1979 , that (I) (we) last saw the deceased alive on August 27, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (I) (did) not view the body after death.											
22b. SIGNATURE <i>C. J. Houmann</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-27-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. J. Houmann, M.D.						22e. ADDRESS 4404 Queensbury Rd., Riverdale, Md. 20840					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/30/79		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md.					
24. FUNERAL DIRECTOR Francois Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland						25a. DATE REC'D. BY REGISTRAR AUG 28 1979		25b. REGISTRAR'S SIGNATURE <i>Henry McBurney</i>			

BP

Francis Gault & Son Funeral Home, Inc.
Baltimore, Maryland

AUG 28 1919

Funeral Home, Inc. Baltimore, Maryland

Francis Gault & Son Funeral Home, Inc.
Baltimore, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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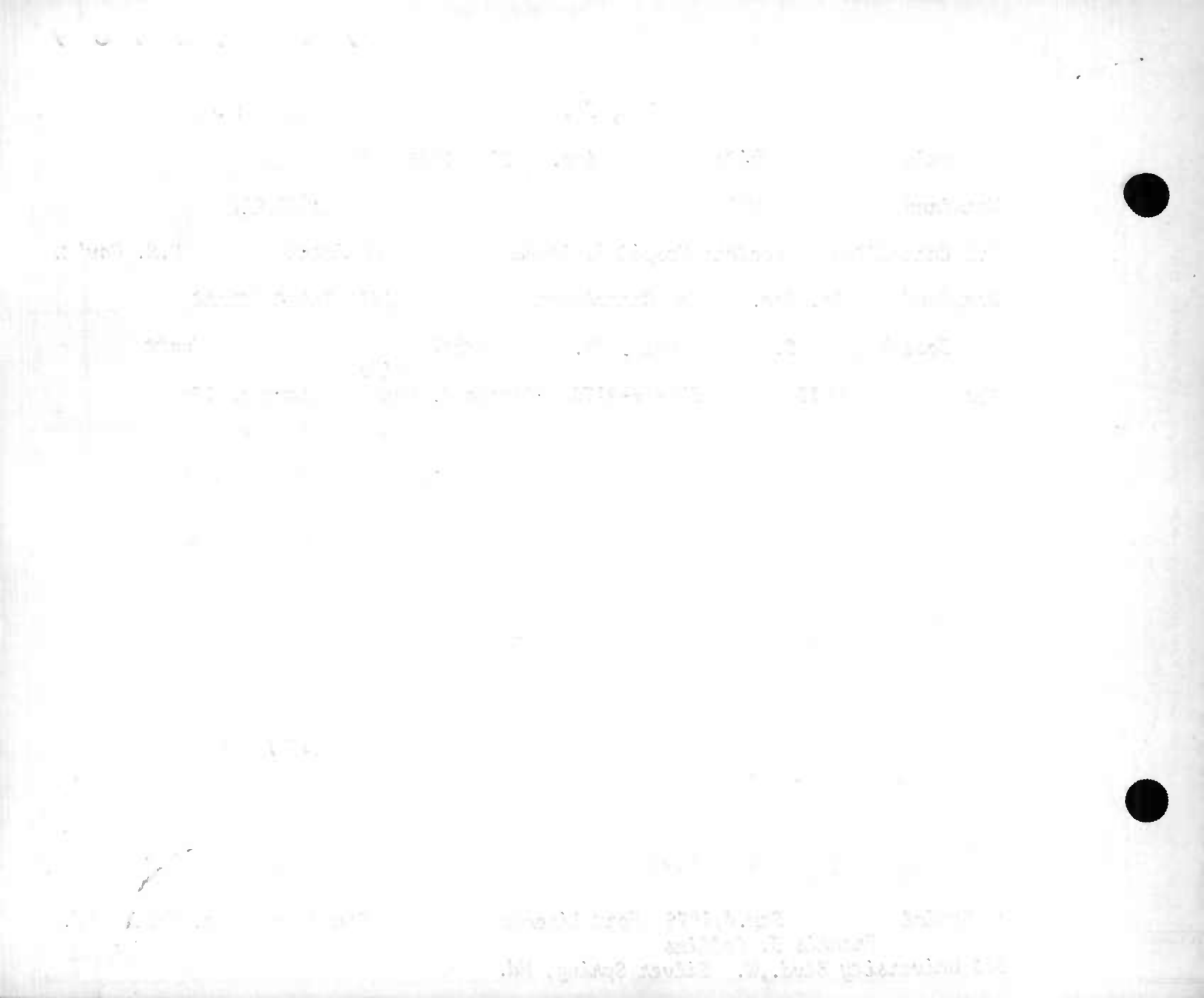
1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9

2 0 6 6 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joseph Stanley BURCH, Jr.			2a. DATE OF DEATH MONTH DAY YEAR August 31, 1979		2b. HOUR 5:14a.m.
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Aug. 28 1923		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Pr. George MD.	
10. CITY OR TOWN OF DEATH Lanham	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital, Lanham		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer	12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
13a. STATE Maryland			13b. COUNTY Pr. Geo.	13c. CITY OR TOWN New Carrollton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Joseph S. Burch, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Knott		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 579-16-9176		17. INFORMANT wife Blanche B. Burch ADDRESS same as 13c	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK. PUMP FAILURE 410 - DUE TO, OR AS A CONSEQUENCE OF Acute Inferior lateral wall (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF coronary artery disease (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Arrhythmia					
19a. DATE OF OPERATION 8/30/79 8/31		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARDIOGENIC SHOCK CVA - stroke. 8/29/79		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 8/31/79	
22a. I certify that (I) (this hospital) attended the deceased from 8/29/79 to 8/31/79, that (I) (we) last saw the deceased alive on 8/30/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE H. RAO MD		DEGREE		22c. DATE SIGNED 8/31/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. RAO S. RAO		22e. ADDRESS Do Hous 10584th - LANHAM 868-7700 552-8400x25		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Sep. 4, 1979	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.	
24. FUNERAL DIRECTOR NAME Francis J. Collins ADDRESS 500 University Blvd., W. Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR SEP 5 1970		25b. REGISTRAR'S SIGNATURE H. RAO	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

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#14,15, Film G534 8/22/79 kam

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

7 9

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1 - STATE REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY Virginia BURDYSKI			2a. DATE OF DEATH MONTH DAY YEAR 08 01 79		2b. HOUR 11:21 P^M	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR March 1, 1933		
6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D C		7b. CITIZEN OF WHAT COUNTRY? U S A		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.		
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		
12b. KIND OF BUSINESS OR INDUSTRY Home		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md		13b. COUNTY Pro Georges		
13c. CITY OR TOWN Mt Rainier		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3104 Webster St		
14. FATHER'S NAME FIRST MIDDLE LAST George M Brown, II			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Biehl L. Biehl			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217 32 3291		17. INFORMANT ADDRESS Lucy A Banting Landover, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery DUE TO, OR AS A CONSEQUENCE OF (c) Diabetic Mellitus 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Hypertension						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from July 1, 1979 to Aug 1, 1979 , that (I) (we) lost saw the deceased alive on July 28, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Ciro D. Montanez		DEGREE MD		22c. DATE SIGNED 8-2-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CIRO D. MONTANEZ		22e. ADDRESS 5108 Dodge PK Rd Lanham				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug 4, 1979		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Hoadley Prince Williams Va		24. FUNERAL DIRECTOR NAME F. Gasch's Sons P A Hyattsville, Md.		25a. DATE REC'D. BY REGISTRAR AUG 6 1979		
25b. REGISTRAR'S SIGNATURE Anthony McCreedy						



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 20671	
1. DECEASED NAME (TYPE OR PRINT) Tammy Mae Burke						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 8 17 19 79		2b. HOUR 5:00			
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 28, 1965	6. AGE (IN YEARS) LAST BIRTHDAY 13 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 8 17 19 79		2d. HOUR A			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD.					
10. CITY OR TOWN OF DEATH Camp Springs		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Andrews Air Force Base Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY Public Jr. High School			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY Pb. Geo's		13c. CITY OR TOWN Forestville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2729 Lorrington Dr., Apt. 303			
14. FATHER'S NAME FIRST MIDDLE LAST Gerald L. Burke				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Joan - - Burghus							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. --		17. INFORMANT Gerald L. Burke ADDRESS 2729 Lorrington Dr., Apt. 303, Forestville Md. 20028					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute ethanol intoxication Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. 8600 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MIN MONTH DAY YEAR 11:30 8/16/ 19 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self ingested					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Parking Lot		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Viceroy Ave. Forestville, P.G. Co., Md.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Margie A. Korell				TITLE (SPECIFY) Assistant		MEDICAL EXAMINER		DATE SIGNED 8/17/79			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/21/79		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood (Pr. Geo's) Md.					
24. FUNERAL DIRECTOR Richard A. Coleman				25a. DECEASED BY REFUSAL FOR SEP 4 1979		25b. FUNERAL HOME Funeral Home Md. 20870:					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR 1 - STATE REGISTRAR					REG. NO. 9 20672				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MAY V BURNS					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR 08 22 79 10:20A.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 27, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Prince George 13c. CITY OR TOWN Riverdale					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5426 50th Ave.		
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Moorman					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucinda Breeden				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579 26 7317		17. INFORMANT Luther Wright General Del.			ADDRESS Pomfret Md. 20675		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) Congestive Heart failure									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8-8-79 to 8-22-79, that (I) (we) last saw the deceased alive on 8-21-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Virender					DEGREE M.D.			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VIRENDER PAL SINGH					22e. ADDRESS 3700 East West Highway #100 Hyattsville Md. 20904				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/25/79		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemt.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md.			
24. FUNERAL DIRECTOR NAME W.W. Chambers Co. Riverdale Md.					25a. DATE REC'D. BY REGISTRAR AUG 31 1979		25b. REGISTRAR'S SIGNATURE Lester McBratney		

MEDICAL CERTIFICATION

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PRINCE GEORGES

PRINCE GEORGES GENERAL HOSPITAL

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CHIEF OF POLICE

Investigation

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Investigation Report Form

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 0 6 7 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) BENJAMIN F. BUSBY, Jr.				2a. DATE OF DEATH MONTH DAY YEAR Aug. 28 1979			
3. SEX Male				2b. HOUR 5:45 P.M.			
4. RACE Caucasian				5. DATE OF BIRTH MONTH DAY YEAR 9 20 02			
6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Louisiana				7b. CITIZEN OF WHAT COUNTRY? USA			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.			
10. CITY OR TOWN OF DEATH CLINTON, MD.				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CLINTON CONVALESCENT CENTER			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman				12b. KIND OF BUSINESS OR INDUSTRY Maps			
13a. STATE D.C.				13b. COUNTY WASH. D.C.			
13c. CITY OR TOWN WASH. D.C.				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS 4312 GARRISON ST. N.W.							
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin F. Busby				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florida Racolly			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 075-10-40 19			
16c. IMMEDIATE CAUSE (a) Cerebral Vascular Accident				17. INFORMANT ADDRESS Hazel M Gallenne, Friend. Same as item 13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4280 DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) 				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 2/18 1979 , to 8/28 1979 , that (I) (we) lost the deceased alive on 8/28 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Racolly DEGREE 				22c. DATE SIGNED 8/28/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KEZA MORTON				22e. ADDRESS 4235 26 Ave NW 20031			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8/31/1979			
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland			
24. FUNERAL DIRECTOR NAME JOSEPH CAWLER'S SONS INC.				25a. DATE REC'D. BY REGISTRAR SEP 6 1979			
25b. REGISTRAR'S SIGNATURE Racolly							

MEDICAL CERTIFICATION

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1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SAXON IMOGENE BUTLER			2a. DATE OF DEATH MONTH AUGUST DAY 23 YEAR 1979			2b. HOUR 0410A M				
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH MAY DAY 10 YEAR 1928		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.				
10. CITY OR TOWN OF DEATH ANDREWS AFB MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND			13b. COUNTY UPPER MARLBORO		13c. CITY OR TOWN UPPER MARLBORO		13d. STREET ADDRESS 4910 ASHFORD DR			
14. FATHER'S NAME FIRST EDWIN MIDDLE JACK LAST KENT			15. MOTHER'S MAIDEN NAME FIRST MAE MIDDLE G LAST KENT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO 228-28-5884		17. INFORMANT JAMES W. BUTLER				ADDRESS 4910 ASHFORD DR UPPER MARLBORO, MD 20870	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure DUE TO, OR AS A CONSEQUENCE OF (b) Acute Resp. Failure DUE TO, OR AS A CONSEQUENCE OF (c) COPD & acute bronchospasm APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 22 AUG 19 79 , to 23 AUG 19 79 , that (I) (we) last saw the deceased alive on 23 AUG 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Glenn Cockerham DEGREE						22c. DATE SIGNED 23 AUG 79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GLENN C. COCKERHAM						22e. ADDRESS MALCOLM GROW USAF MEDICAL CENTER ANDREWS AFB, MD 20331				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/25/79		23c. NAME OF CEMETERY OR CREMATORY Rose Park Sec 4		23d. LOCATION CITY OR TOWN Madison County STATE VA			
24. FUNERAL DIRECTOR NAME W. Prody			ADDRESS ORANGE, VA		25a. DATE REC'D. BY REGISTRAR AUG 30 1979		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

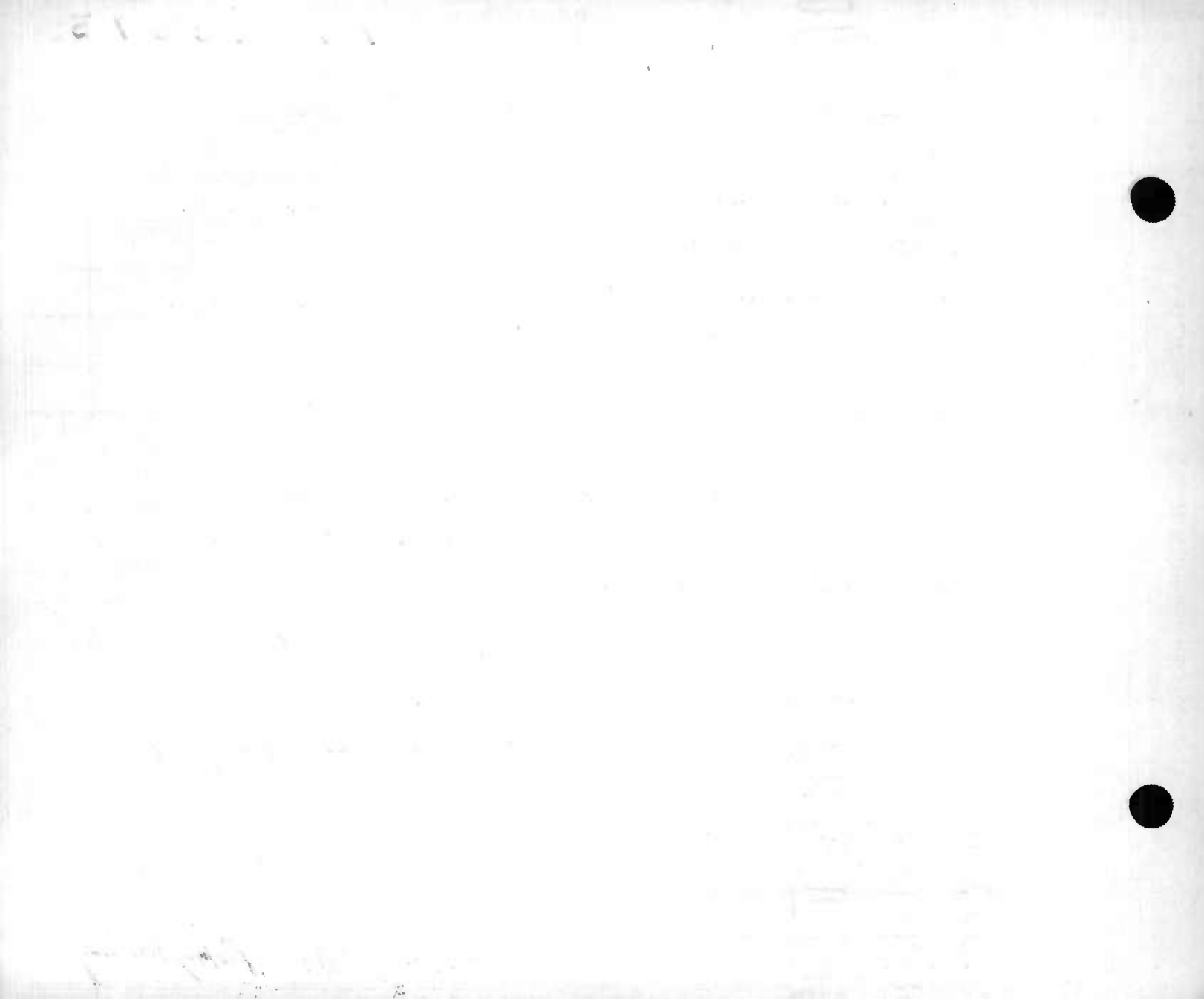
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 7 9 20675									
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Lillian		E		CARN				8-18-79		M	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Cauc.		7 MONTH 25 DAY 1898		81		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Phila. Pa.		U.S.A.				Prince George Co. MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Greenbelt		Greenbelt Conv. Home						Housewife			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.		P.G. Co.		Hyattsville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6706 W. Forest Rd.			
14 FATHER'S NAME						15. MOTHER'S MAIDEN NAME					
Daniel						Mary Elizabeth					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS			
No								Louie Atwell Same as 13 e			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) coronary occlusion										10 min	
410- DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerosis heart disease										2 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) hypertension - congestive heart failure										9 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):											
One Peter weller											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from Aug 5th 1978 to Aug 18th 1979, that (I) (we) lost saw the deceased alive on Jul 19th 1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
T. A. Hardesty		MD				Aug 18th 79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY STATE	
Burial		8-21 1979		WoodField		Galesville		A.A. Md.			
24 FUNERAL DIRECTOR NAME				24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE					
T. A. Hardesty				Annapolis MD 21401		AUG 21 1979		T. A. Hardesty			



7-18-22a Film G534 8/21/79 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20676

1- FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
 Dolores Marie Carobrese

2a. DATE OF DEATH KNOWN OF ESTI-MATED ☒ 7 16 19 79 7b. HOUR M
 3:24 A M

3. SEX Female 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR Aug. 23, 1923 6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS. 7. IF UNDER 1 YR. MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN. 9. DATE PRONOUNCED DEAD 7 17 19 79 10. CITY OR TOWN OF DEATH Cheverly 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital (DOA) 12. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County, MD. 13. STATE Maryland 13b. COUNTY Prince Georges 13c. CITY OR TOWN Bowie 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS 13503 Old Chapel Road

14. FATHER'S NAME FIRST MIDDLE LAST William Daneko 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Taylor

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no 16b. SOCIAL SECURITY NO. 155-14-3999 17. INFORMANT ADDRESS August M. Carobrese, 13503 Old Chapel Rd. Bowie, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Carbon Monoxide Intoxiciation
 9520
 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
 (b) DUE TO, OR AS A CONSEQUENCE OF
 (c) DUE TO, OR AS A CONSEQUENCE OF
 PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? 7/16/ 19 79 P.M. 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject inhaled exhaust fumes from automobile

21d. INJURY OCCURRED WHILE ☐ AT WORK ☐ NOT WHILE ☒ AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) garage of home 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 13503 Old Chapel Rd. Bowie, Pg. Geo. Co. Md.

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE Virginia L. Dolan, M.D. M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 7/18/79

EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D. ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE July 20, 1979 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland

24. FUNERAL DIRECTOR Robert G. Beall Lanham Funeral Home 25a. DATE REC'D. BY REGISTRAR JUL 26 1979 25b. REGISTRAR'S SIGNATURE

26. FUNERAL HOME 9013 Annapolis Road, Lanham, Maryland



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20677
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE ESTIMATED		2d. HOUR	
Aaron Reynolds Carzon		8 15 19 79		4:54 P M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	7. IF UNDER 24 HRS.
Male	White	Dec 11, 1976	2 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Cheverly		Prince George's General Hospital (DOA)		n/a	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Pr. Geo.		Riverdale	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
William Alvin Mitchell		Anita Carzon		n/a	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
no		n/a		William Mitchell Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1 DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Drowning</u>					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					
(b) <u>9109</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		Noon P.M. 8 15 19 79		Subject fell into water and drowned	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
		water		Glen Dale Lake, Greenbelt, Prince George's, Md	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Margarita A. Korell		Assistant		8/17/79	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Margarita A. Korell, M.D.		111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		18 AUG 79		Cedar Hill Cemetery	
24. FUNERAL DIRECTOR NAME		24b. DATE REC'D. BY REGISTRAR		25. REGISTRAR'S SIGNATURE	
Robert G. Beall Funeral Home		AUG 23 1979		Anthony McCurdy	
9013 Annapolis Rd. Lanham, Md. 20801					

20317





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

#17, F1mG535 9/17/79 kam

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20678

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Elsie E. Chester			2a. DATE OF DEATH MONTH DAY YEAR August 30, 1979		2b. HOUR 10:20 P.M.								
3. SEX F		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Feb. 13, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 2 YRS. MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Guyana, S. America		7b. CITIZEN OF WHAT COUNTRY? Guyana		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges County MD.							
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel Beltsville Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) mess attendant		12b. KIND OF BUSINESS OR INDUSTRY food service co.					
13a. STATE Md						13b. COUNTY P. G.		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 401 Cherry Lane	
14. FATHER'S NAME FIRST MIDDLE LAST Savory				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Lyken									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213 72 5462		17. INFORMANT W. ADDRESS Rufus M. Chester same as above									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u> <u>1560</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic carcinoma</u> (Cancer blood) DUE TO, OR AS A CONSEQUENCE OF (c) <u>underlying cause last.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 minutes			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION Aug 15		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Small Bowel obstruction				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOE-WHITE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>July 22</u> , 19 <u>79</u> , to <u>August 30</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>August 30</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Stuart E. Selonick, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 8/30/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart E. Selonick, M.D.				22e. ADDRESS Laurel Hospital Laurel, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4, 1979 Sept		23c. NAME OF CEMETERY OR CREMATORY National Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, Maryland							
24. FUNERAL DIRECTOR [Signature]				25a. DATE REC'D. BY REGISTRAR SEP 10 1979				25b. REGISTRAR'S SIGNATURE [Signature]					

BP

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20679

1. FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) MATILDA		FIRST L.		MIDDLE CHEW		LAST		2a DATE OF DEATH MONTH DAY YEAR 08 28 79		2b HOUR 12:08A.M.	
3 SEX Female		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR 11 03 30		6 AGE (IN YEARS LAST BIRTHDAY) 49		IF UNDER 1 YEAR MONTHS DAYS YRS		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD					
10 CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.		13b COUNTY Pr. Georges		13c CITY OR TOWN Brandywine		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS Rt. 1 Box 437A			
14 FATHER'S NAME FIRST MIDDLE LAST Andrew Matthews				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Linnie Chase							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 217 72 7619		17 INFORMANT Clarence A. Chew				ADDRESS Brandywine, Md. Rt 381 Bx337			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular arrest 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: b) respiratory failure c) concomitant carcinoma of lung										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.											
19a DATE OF OPERATION*		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 8/22 19 79 to 8/27 19 79 , that (I) (we) last saw the deceased alive on 8/27 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Robert S. Castonice				DEGREE				22c. DATE SIGNED 8/28/79			
22d PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT S. CASTONICE				22e ADDRESS 930 S. St. Parnassus							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 1, 1979		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Landover Maryland					
24. FUNERAL DIRECTOR NAME RG Mason Inc				ADDRESS 1661 Good Hope Rd				25a. DATE REC'D. BY REGISTRAR (25b. REGISTRAR'S SIGNATURE) AUG 31 1979			

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP

DHMH - 17
(VR A15 ME (5))
15M7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										20681 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Willie LEE CLARK							2a. DATE KNOWN OF DEATH MONTH DAY YEAR 8-16 1979		2b. HOUR M 10		
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 3-3-93	6. AGE (IN YEARS) LAST BIRTHDAY 86 YRS.	IF UNDER 1 YR. MONTHS DAYS 0 0	IF UNDER 24 HRS. HOURS MIN 0 0	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8-16 1979		2d. HOUR M 10			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sts Hospital (md)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Beautician		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 611-Fla. Ave N.E			
14. FATHER'S NAME FIRST MIDDLE LAST Richard Joshua Reynolds				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Henny Galloway							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 23566 4386		17. INFORMANT ADDRESS Gloria Johnson 7900 Ashdale Rd Dist Heights					
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE Anemia, pulmonary thromboembolism DUE TO, OR AS A CONSEQUENCE OF (b) Right intertrochanteric fracture DUE TO, OR AS A CONSEQUENCE OF (c) 888- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Arteriosclerosis											
19a. DATE OF OPERATION 7-19-79				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Intertrochanteric fracture				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:30 P.M. 7-16 1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fell on hallway outside the bathroom					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 7900 Ashdale Rd, District Heights, Pr. Georges, Md		21g. LOCATION CITY OR TOWN COUNTY STATE Dist Heights, Pr. Georges, Md			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										20027	
ACTUAL SIGNATURE Augusto P. Rodriguez				TITLE (SPECIFY) Deputy				DATE SIGNED 8-17-79			
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.				ADDRESS 5009 Rayburn Ct., Camp Springs, Md. 20031							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-24-79		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial				23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAME William F. Magruder				ADDRESS 2311 M.L. King Ave S.E. Wash				25a. DATE RECEIVED BY REGISTRAR AUG 21 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

1 2 3 4 5

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

20682

FOR
STATE
REGISTRAR

REG. NO.

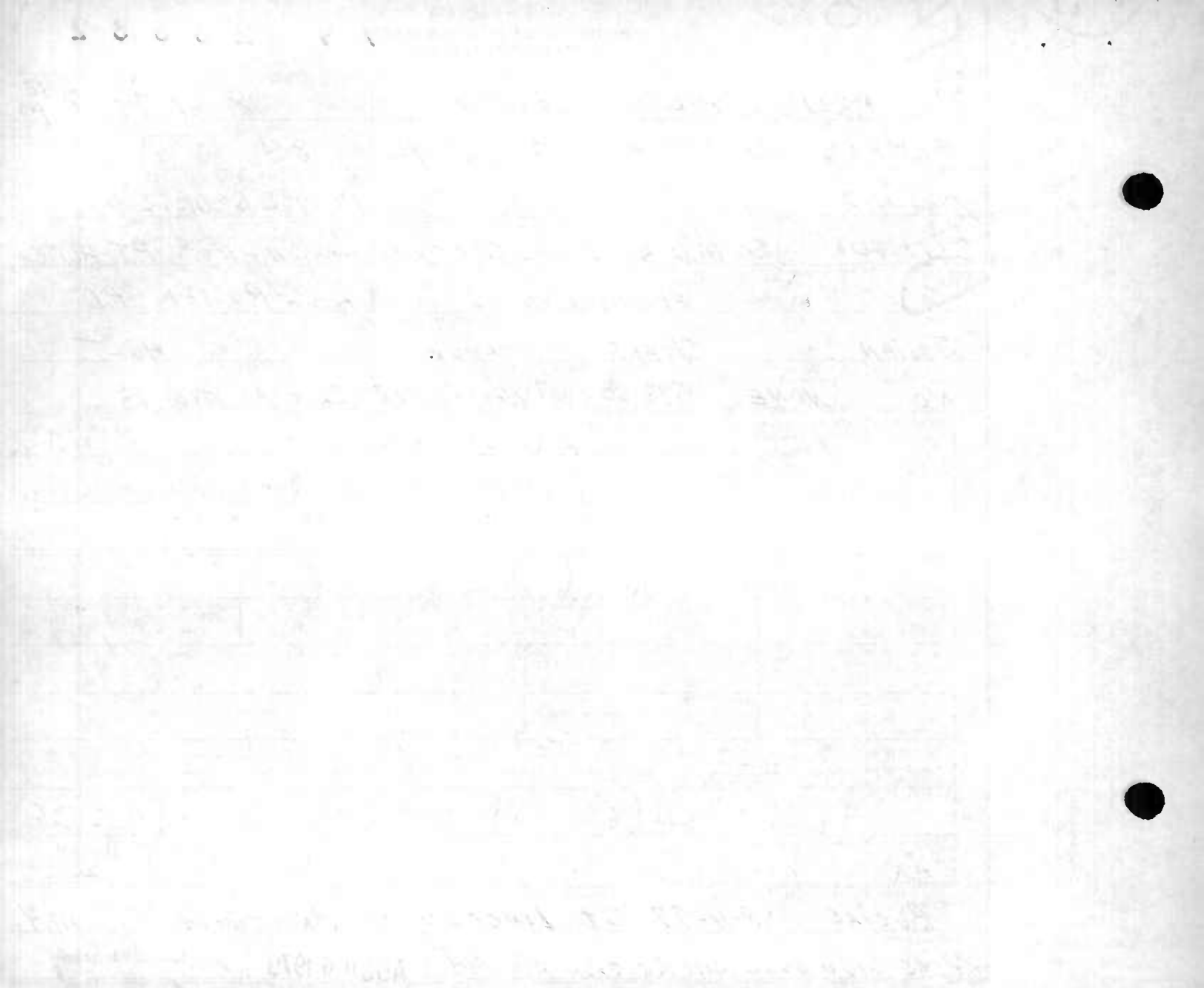
1 DECEASED NAME (TYPE OR PRINT) BELLE BERTHELY COBURN		2a DATE OF DEATH MONTH 8 DAY 1 YEAR 79		2b HOUR 8 PM
3 SEX FEMALE	4 RACE CAUCASIAN	5. DATE OF BIRTH MONTH 9 DAY 24 YEAR 94		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.
10 CITY OR TOWN OF DEATH CLINTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SO MD HOSPITAL CENTER		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY AT HOME
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				
13a STATE MD	13b COUNTRY US	13c CITY OR TOWN FT WASHINGTON	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 436 ROSIER RD
14 FATHER'S NAME FIRST JULIAN MIDDLE SPARS LAST LUCK		15 MOTHER'S MAIDEN NAME FIRST LUCK MIDDLE HOLT LAST HOLT		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 578-50-6037		17. INFORMANT NAN FOSTER ADDRESS SAME AS ITEM 13
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular 10-17-90 DUE TO, OR AS A CONSEQUENCE OF (c) 2nd cerebrovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-6 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Dehydration				
19a. DATE OF OPERATION 4-29-79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Dehydration		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 4-29 , 19 79 , to 8-1 , 19 79 , that (I) (we) last saw the deceased alive on 8-1 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE David N. Robb MD		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-2-79
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID N. ROBB		22e. ADDRESS 9401 Indian Head Hwy Oxon Hill Md 20022		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-4-79	23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEM	
23d. LOCATION CITY OR TOWN Brentwood COUNTY Prince George's STATE MD.		24 FUNERAL DIRECTOR NAME KALAS GIGLO ADDRESS Oxon Hill Rd. Oxon Hill, Md.		
25a. DATE REC'D. BY REGISTRAR AUG 6 1979		25b. REGISTRAR'S SIGNATURE L. J. [Signature]		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	MIN.
MARY		ELIZABETH		Coffman	08	29	79		11:17P.	M.
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female	Caucasian	10 TH 05 YEAR 18		60	MONTHS		DAYS		HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH						
Maryland	U.S.A.			Prince Georges County MD.						
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Clinton	Southern Maryland Hospital Center				Homemaker		Own Home			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS		
Md.		Charles		Waldorf		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 4 Box 65T		
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST		FIRST MIDDLE LAST								
Cleverland		Herbert		Mary E. Gray						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS						
NO		-----		Rt. #4 Box 65 T Lois Jean Sexton Waldorf, Maryland						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY										
IMMEDIATE CAUSE (a) <u>Congestive Cardiac insufficiency and Arteriosclerosis</u>										
4254										
DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>Acute Cholelithiasis of jaundice</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <u>Myocardial Infarction</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
		P.M. 19								
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from <u>8/1</u> 19 <u>79</u> to <u>8/29</u> 19 <u>79</u> that (I) (we) last saw the deceased alive on <u>8/27</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE		DEGREE		22c DATE SIGNED						
<u>G. H. WATKINS MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		8/30/79						
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS								
G. H. WATKINS MD		Char. Prof. Center Waldorf, Md.								
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE				
Cremation		8-30-79		Metropolitan Crematory		Alexandria, VA.				
24 FUNERAL DIRECTOR NAME ADDRESS				25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE				
HUNTT'S Funeral Home, Waldorf, MD.				SEP 4 1979		<u>Robert McCreedy</u>				

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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HUNT'S Funeral Home, Waldorf, MD.

Oronation 8-30-79 Metropolitan Cemetery Alexandria, VA.

MEDICAL EXAMINER NOTICE D

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 20684							
1 DECEASED NAME (TYPE OR PRINT) JOSEPH M. COLLINS					2a DATE OF DEATH MONTH 8 DAY 31 YEAR 79		2b HOUR 5:45AM		
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH 7 DAY 1 YEAR 1897		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS		7 IF UNDER 1 YEAR MONTHS DAYS 	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? Prince Georges		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD			
10 CITY OR TOWN OF DEATH Clinton		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b KIND OF BUSINESS OR INDUSTRY railroad	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.		13b COUNTY P.G.		13c CITY OR TOWN Oxon Hill		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 6421 LIVINGSTON RD. APT. 301	
14 FATHER'S NAME FIRST Joseph MIDDLE LAST Collins					15 MOTHER'S MAIDEN NAME FIRST Alice MIDDLE LAST Myers				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) wwI		17 INFORMANT ADDRESS Marion Collins same as item 13				
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart failure 0389 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Unmyocardial Infarction (c) Sepsis -								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH day	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Diabetes (New)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 8/30 19 79 to 8/30 19 79 , that (I) (we) last saw the deceased alive on 8/30 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE R. E. 2A						DEGREE REGISTERED		22c DATE SIGNED 8-31-79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) R. E. 2A						22e ADDRESS 4235 25th Ave md 21031			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 9/4/79		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Suitland Md.		
24 FUNERAL DIRECTOR NAME G.P. Kalas ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.						25a DATE REC'D. BY REGISTRAR SEP 4 1979		25b REGISTRAR'S SIGNATURE Jeffrey McBrady	



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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours in accordance with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 2 0 6 8 5			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) James W. COOK			2a. DATE OF DEATH August 25, 1979			2b. HOUR 11:50 P M	
3 SEX Male	4 RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Jan 6 14		6 AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's County MD.			
10 CITY OR TOWN OF DEATH Glenn Dale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Glenn Dale Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian		12b. KIND OF BUSINESS OR INDUSTRY Private	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Wash.		13b. COUNTY -	13c. CITY OR TOWN D.C.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1010 4th St N.E.	
14 FATHER'S NAME FIRST MIDDLE LAST James Cook			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Pearson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-20-3112		17 INFORMANT Sister ADDRESS Evelyn Colvin same as item 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia secondary to aspiration							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours
19. 5070 CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Cerebrovascular accident with left hemiplegia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 24 19 78 , to Aug. 25 19 79 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Aug. 25 19 79 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. If (we) did not view the body after death.							
22b. SIGNATURE <i>James Wills M.D.</i>						22c. DATE SIGNED August 25, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James W. Wills, M.D.				22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland 20769			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-30-79		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Landover, Maryland PG	
24. FUNERAL DIRECTOR NAME ADDRESS FRAZIER'S 389 Rhode Island Ave N.W.				25a. DATE REC'D. BY REGISTRAR SEP 4 1979		25b. REGISTRAR'S SIGNATURE <i>L. J. McCurdy</i>	

BP _____

2010

The first of the following is a list of the names of the persons who have been appointed to the various positions in the various departments of the Government of the United States of America.

and the names of the persons who have been appointed to the various positions in the various departments of the Government of the United States of America.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PREPARE AND EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										200686 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) MARINO CORSETTI										2a. DATE KNOWN OF DEATH MONTH 7 DAY 6 YEAR 1979	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 10 DAY 25 YEAR 1905	6. AGE (IN YEARS) (LAST BIRTHDAY) 73 YRS.	7. IF UNDER 24 HRS. MONTHS 0 DAYS 0 HOURS 0 MIN.	2c. DATE PRONOUNCED DEAD MONTH 7 DAY 7 YEAR 1979		2b. HOUR 10:21		2d. HOUR 10:21		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges		MD.			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) D.O.A. Prince Georges Gen. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chief Engineer (Ret)		12b. KIND OF BUSINESS OR INDUSTRY Broad. Co.		Natl.	
13a. STATE D.C.		13b. COUNTY Washington DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS 5713 Western Avenue NW					
14. FATHER'S NAME FIRST Joseph MIDDLE Corsetti LAST Corsetti				15. MOTHER'S MAIDEN NAME FIRST Anelda MIDDLE Anelda LAST Corsetti							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-10-6647		17. INFORMANT Marguerite		ADDRESS 13		17. INFORMANT Marguerite Corsetti, Wife. Same as item			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crush injury of chest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR 7 A.M. MONTH 7 DAY 7 YEAR 1979 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Pinned by own farm tractor					
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) His Farm		21f. LOCATION STREET 2410 Chain Highway CITY OR TOWN Upper Marlboro COUNTY Prince Georges STATE Md.					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Augusto P. Rodriguez				M.D. Deputy				MEDICAL EXAMINER 5009 Rayburn Court, Camp Springs			
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez				ADDRESS 5009 Rayburn Court, Camp Springs				DATE SIGNED 7-7-79			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/10/1979		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery				23d. LOCATION CITY OR TOWN Silver Spring, Md. COUNTY Montgomery STATE Md.			
24. FUNERAL DIRECTOR NAME JOSEPH GAWLER'S SONS INC. 5130 WISSE AVE., N. W. WASH., D. C. 20040				25a. DATE REC'D. BY REGISTRAR JUL 12 1979				25b. REGISTRAR'S SIGNATURE Henry McBrady			



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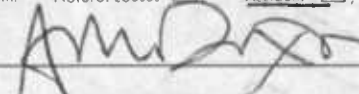
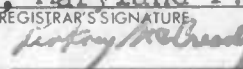
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF THE DEATH IS SUSPECTED, THE CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF THE DEATH IS SUSPECTED, THE CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF THE DEATH IS SUSPECTED, THE CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										2006-87	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) NATIVIDAD G. COSCA						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 8 22 1979		2b. HOUR M			
3. SEX female		4. PLACE OF BIRTH Philippines		5. DATE OF BIRTH MONTH April DAY 25 YEAR 1937		6. AGE (IN YEARS LAST BIRTHDAY) 42		7. IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		7c. DATE PRONOUNCED DEAD MONTH 8 DAY 22 YEAR 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Philippines		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's Co. MD.					
10. CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital				12a. USUAL OCCUPATION (NATURE OF WORK FOR MOST OF WORKING LIFE) Rec. Central Services Hospital					
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Camp Springs		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6908 Berkshire Drive			
14. FATHER'S NAME FIRST Felix Gonzales MIDDLE LAST 				15. MOTHER'S MAIDEN NAME FIRST Mariaelena Faustino MIDDLE LAST 							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 579-86-4742		17. INFORMANT ADDRESS Benjamin F. Cosca (Husband) Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries with complications 8120 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7:03pm 8-2-1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Driver of auto/truck collision.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET Rt. 5 & Surratt Rd., CITY OR TOWN Clinton, COUNTY P.G. STATE Md.					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE 				TITLE (SPECIFY) Assistant				DATE SIGNED 8-23-79			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8/25/79		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION CITY OR TOWN Clinton, COUNTY Maryland STATE P.G.			
24. FUNERAL DIRECTOR NAME Lee Funeral Home Inc. ADDRESS 6633 Old Alexander Ferry Rd. Clinton, Md.				25a. DATE REC'D. BY REGISTRAR AUG 27 1979		25b. REGISTRAR'S SIGNATURE 					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		9 20688 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALLAN E COX						2a. DATE OF DEATH MONTH DAY YEAR 08 14 79		2b. HOUR 2:00P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 2 1924		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Loan Specialist		12b. KIND OF BUSINESS OR INDUSTRY Dept. of Agri.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY Maryland Pr. George						13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Cox						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Allen			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS Elizabeth E. Wesley		6609 Patterson St. Riverdale Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 4275 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DO NOT TO BE FILLED IN BY THE REGISTRAR								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Hypertension</u> <u>Peripheral vascular disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 1</u> 19 <u>75</u> , to <u>AUG 14</u> 19 <u>75</u> , that (I) (we) last saw the deceased alive on <u>AUG 14</u> 19 <u>75</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>David M. Goldman</u> MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/15/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David M. Goldman						22e. ADDRESS 6525 Belcrest Rd., Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/17/79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. George Md.			
24. FUNERAL DIRECTOR NAME ADDRESS <u>Steph P. Palas</u> 6160-EXTRA NEE						25a. DATE REC'D. BY REGISTRAR AUG 20 1979		25b. REGISTRAR'S SIGNATURE <u>Patrick McBrady</u>	

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301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400
401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500
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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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20689

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) David N. Crismond		2a DATE OF DEATH MONTH DAY YEAR 8 25 79		2b HOUR 1:45p_M	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 9/ 22 17	
6 AGE (IN YEARS LAST BIRTHDAY) 61 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8 IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 BALTIMORE CITY OR COUNTY OF DEATH PG MD.		10 CITY OR TOWN OF DEATH Clinton		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Md. Hospital Center	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b KIND OF BUSINESS OR INDUSTRY Painting		13a INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13b STREET ADDRESS 615 Carson Avenue		14 FATHER'S NAME FIRST MIDDLE LAST Nelson Page Crismond		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara E. Gallahan	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 224-09-9923		17 INFORMANT Mary N. Crismond	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Vasculitis & acute myocardial infarction 4476 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Rheumatoid arthritis					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 8-17 19 79 to 8-25 19 79 , that (I) (we) last saw the deceased alive on 8-24 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b SIGNATURE W.K. Furst		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 8-25-79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) W. K. Furst		22e ADDRESS 9401 Indian Head Highway, Oxon Hill, Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 8/28/79		23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
23d LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.		24 FUNERAL DIRECTOR NAME ADDRESS George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md.			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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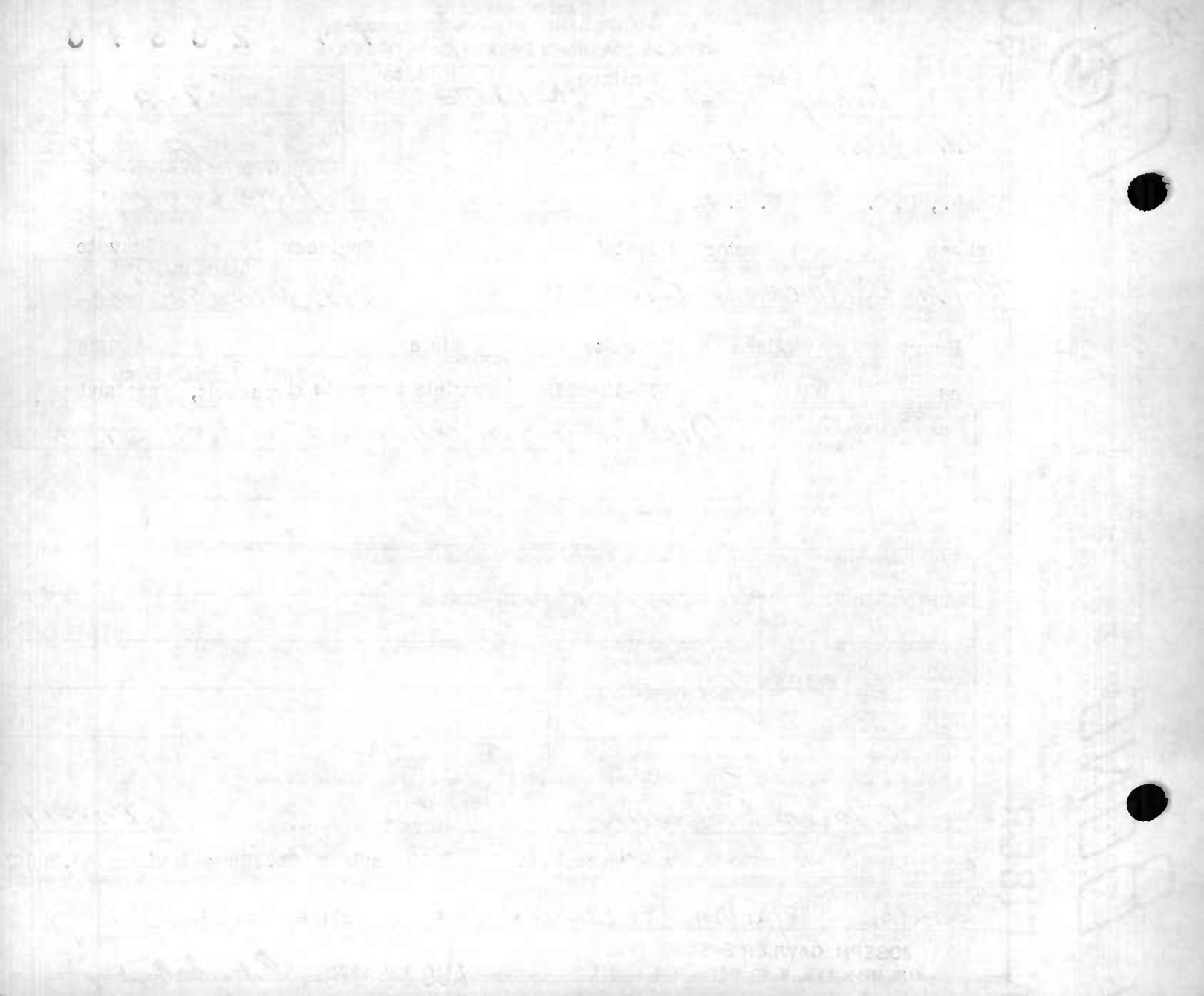
FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20690
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Henry Wallace Cronkite			2a. DATE KNOWN OF DEATH ESTI- MATED 8-18-79			2b. HOUR 4:00		
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10-17-21	6 AGE (IN YEARS) LAST BIRTHDAY 57 RS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD 8-18-79	7d. HOUR 4:00	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.		
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Private	
13a. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Prince Georges Greenbelt				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Mandan Road		
14. FATHER'S NAME FIRST MIDDLE LAST Henry Wallace Cronkite			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Adams			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII		
16b. SOCIAL SECURITY NO. 579-12-6219			17. INFORMANT ADDRESS 7917 Mandan Road Virginia Cronkite Greenbelt, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic arteriosclerotic cardiovascular disease 2507 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Augusto P. Rodriguez			TITLE (SPECIFY) Deputy M.D. Deputy MEDICAL EXAMINER			DATE SIGNED 8-18-79		
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.			ADDRESS 5009 Rayburn Ct., Camp Springs, Md. 20031					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8/21/79		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD, MD.	
24. FUNERAL DIRECTOR NAME JOSEPH CAWLER'S SONS INC.					25a. DATE REC'D. BY REGISTRAR AUG 22 1979			
25b. REGISTRAR'S SIGNATURE Augusto P. Rodriguez								

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILE.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



Item 85355 9/6/79 gj

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

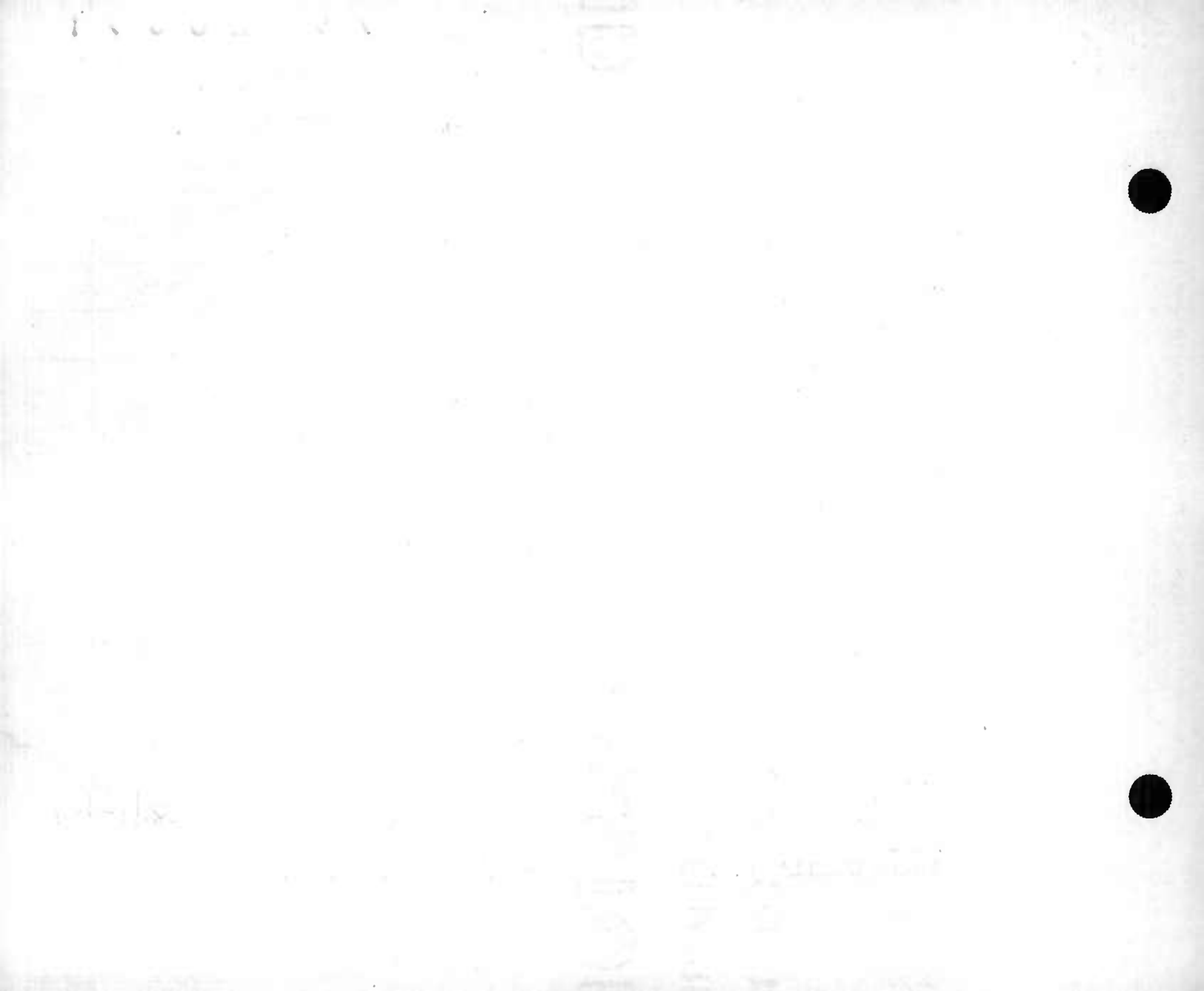
REG. NO.

7 20691

1. DECEASED NAME (TYPE OR PRINT) DRAG H. DAVALL			2a. DATE OF DEATH MONTH 08 DAY 15 YEAR 79			2b. HOUR 5:00 AM					
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH 9 DAY 21 YEAR 34		6. AGE (IN YEARS LAST BIRTHDAY) 44 YRS.		IF UNDER 1 YEAR MONTHS 00 DAYS 00		IF UNDER 74 HRS HOURS 00 MIN 00	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.					
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN EACH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGES GENERAL HOSPITAL						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD.		13b. COUNTY P.G.		13c. CITY OR TOWN LANDOVER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2519A Kent Town Drive,			
14. FATHER'S NAME FIRST JOHN MIDDLE DAVALL LAST DAVALL				15. MOTHER'S MAIDEN NAME FIRST UNKNOWN MIDDLE UNKNOWN LAST UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) KOREAN		17. INFORMANT ADDRESS MRS. SARAH DAVALL, WIFE 2519A Kent Town Dr.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive GI bleeding DUE TO, OR AS A CONSEQUENCE OF (b) Esophageal Varices DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Alcoholism										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that (I) (this hospital) attended the deceased from 8-15-1979 , to 8-15-1979 , that (I) (we) lost saw the deceased alive on 8-15-1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22a. SIGNATURE Joseph Colella				DEGREE				22c. DATE SIGNED 8/15/79			
22b. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH COLELLA M.D.				22e. ADDRESS PGGH/MC, CHEVERLY, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8/20/79		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL			23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON, VA.			
24. FUNERAL DIRECTOR NAME HALL BROS. FUNERAL HOME ADDRESS 621 FLA. AVE., N.W.						25a. DATE REC'D. BY REGISTRAR AUG 17 1979		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M/7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOROTHY W. DAVIS			2a. DATE OF DEATH MONTH DAY YEAR 08-27-79		2b. HOUR 8:22 PM	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 21, 1921		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		6 AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S MD.		
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Receptionist			12b. KIND OF BUSINESS OR INDUSTRY Sys. Dev. Corp.			
13a. STATE Maryland			13b. CITY OR TOWN Prince Geo.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13d. STREET ADDRESS 8-T Laurel Hill Road						
14 FATHER'S NAME FIRST MIDDLE LAST Will - Wright			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine - Starie			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) -		17 INFORMANT ADDRESS Christine Bell-Address same as #13 above.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive failure</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>8-27</u> , 19 <u>79</u> , to <u>8-27</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>8-27</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Abolghassem Hatef</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8-28-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Abolghassem Hatef				22e. ADDRESS Prince Geo. Genl. Hosp.-Cheverly, Md. 20785		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 30, 1979		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland-Prince Geo. Co.-Md.						
24 FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.				25a. DATE REC'D. BY REGISTRAR SEP 5 1979		
25b. REGISTRAR'S SIGNATURE M D						

MEDICAL CERTIFICATION

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6704 BP

SEP 5 1979

14

DAVID

DAVID

01-27-79

8:22 PM

CHURCH

PRINCE GEORGE'S GENERAL HOSPITAL

PRINCE GEORGE'S GENERAL HOSPITAL

DATE

TIME

LOCATION

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 2 0 6 9 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph Edwin Deavers				2a. DATE OF DEATH MONTH DAY YEAR August 31, 1979		2b. HOUR 11:21AM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 21 1918		6. AGE (IN YEARS LAST BIRTHDAY) 61		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH P.G.		
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN INSTITUTION, GIVE STREET ADDRESS) Prince Georges General		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Lumber Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY P.G.		13c. CITY OR TOWN Cottage City	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Edward Deavers				15. MOTHER'S MAIDEN NAME FIRST MIDDLE Ethel M. Pumphrey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 212-09-5445		17. INFORMANT ADDRESS Hilda P. Deavers Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrhythmia 4280 DUE TO, OR AS A CONSEQUENCE OF (b) congestive failure, arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hodgkins disease (lymphoma); renal tumor							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 8/11/79 19 79 , to 8/24/79 19 79 , that (1) (we) lost saw the deceased alive on 8/24 19 79 , and that in (my) (your) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jill Karatimos, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) Jill Karatimos, M.D.				23b. ADDRESS 3231 Superior Lane Suite A-6 Bowie, Md. 20715			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept 4, 1979		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pro Georges Md.	
24. FUNERAL DIRECTOR NAME F. Gasch's Sons P A Hyattsville, Md.				25a. DATE REG'D. BY REGISTRAR SEP 3 1979		25b. REGISTRAR'S SIGNATURE <i>Anthony McBrady</i>	

MEDICAL CERTIFICATION

4400 BP

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
 (VR A15 ME (5))
 15M 7/76

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20694
 REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Drusilla		MIDDLE Mse		LAST Dickerson		2a. DATE OF DEATH KNOWN ESTIMATED <input checked="" type="checkbox"/> <input type="checkbox"/>		MONTH 8		DAY 5		YEAR 1979		7b. HOUR 11:50 AM							
3. SEX female		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 1 2 47		6. AGE (IN YEARS) (LAST BIRTHDAY) 32 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 5 1979		11:50 a.m.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ann. MD				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Prince George County MD											
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George County Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Church Secretary				12b. KIND OF BUSINESS OR INDUSTRY									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																							
13a. STATE MD				13b. COUNTY P. G.				13c. CITY OR TOWN Seat Pleasant				13d. INSIDE CITY LIMITS? NO <input type="checkbox"/>		13e. STREET ADDRESS 6706 Calmos St.									
14. FATHER'S NAME William W. Dyson						15. MOTHER'S MAIDEN NAME Genevieve A. Golson																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No						16b. SOCIAL SECURITY NO. Unk						17. INFORMANT Ms. Golson/Mother											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of renal pedicle with hemoperitoneum</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:55AM 8/5 1979						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver in auto/auto collision											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street						21f. LOCATION STREET CITY OR TOWN COUNTY STATE Central Ave/Addison Rd. PG Co. MD											
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <i>H. R. Guard</i>						TITLE (SPECIFY) Assistant MEDICAL EXAMINER						DATE SIGNED 8/6/79											
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.						ADDRESS 111 Penn Street, Balto., MD 21201																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 8-10-79						23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln						23d. LOCATION CITY OR TOWN Brendwood. P. G. MD.					
24. FUNERAL DIRECTOR NAME Latney's Funeral Home						ADDRESS 3831 Ga., Ave NW						25a. DATE REC'D BY REGISTRAR AUG 14 1979						25b. REGISTRAR'S SIGNATURE <i>Robert M. Brady</i>					



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 74 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										20695 REG. NO.	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <i>Soloma Mary DILLON</i>							2a. DATE KNOWN OF DEATH MONTH DAY YEAR <i>8-13 1979</i>		2b. HOUR AM PM <i>10:09</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11-21-94 84</i>		6. AGE (IN YEARS) LAST YRS. MONTHS DAYS HOURS MIN. <i>84</i>		7c. DATE PRONOUNCED MONTH DAY YEAR <i>8-13 1979</i>		7d. HOUR AM PM <i>10:09</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>				7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i>	
10. CITY OR TOWN OF DEATH <i>Cheverly</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>P.G. Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. RESIDENCE (IF IN HOSPITAL, HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY OR TOWN <i>Maryland Prince Georges District Hts</i>							13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>2301 Rimbewood Drive</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>James T. Raley</i>							15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary E. Duckett</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>Unknown</i>				17. INFORMANT NAME ADDRESS <i>2133 Weber Dr., District Heights, Andrew P. Dillon, Son Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <i>4292</i> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i>				TITLE (SPECIFY) <i>Deputy</i>				DATE SIGNED <i>8-13-79</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez</i>				ADDRESS <i>5009 Bayberry Court Camp Springs</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>8-16-79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Suitland, P.G., Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>Robt E Wilhelm</i>						4308 Suitland		25a. DATE REC'D. BY REGISTRAR <i>AUG 21 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Henry McBrady</i>	
Funeral Home						Rd., Suitland, Md.					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 20696			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALFRED F. DONAGGIO				2a. DATE OF DEATH MONTH DAY YEAR AUG 22 79		2b. HOUR 4:30A M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Nov. 8 18		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS. 60 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD	
10. CITY OR TOWN OF DEATH ANDREWS AFB, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW USAF MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Worker		12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN MARYLAND PRINCE GEORGE CAMP SPRINGS				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6103 RAYBURN DR	
14. FATHER'S NAME FIRST MIDDLE LAST ALFRED NMI DONAGGIO				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GEORGINA NMI SIBALD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1940-1963		17. INFORMANT ADDRESS BERNARDINA DONAGGIO 6103 RAYBURN DR CAMP SPRINGS MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Anterior Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>20 Aug</u> 19 <u>79</u> to <u>22 Aug</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>22 Aug</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE DEGREE <u>Arthur S. Hansman</u> M.D.				22c. DATE SIGNED <u>22 Aug 79</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Arthur S. HANSMAN</u>	
22e. ADDRESS <u>4275 Elm La #1 Andrews AFB, Md 20335</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/28/79		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem. Ft. Myer Arlington Va.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.				25. DATE REC'D. BY REGISTRAR AUG 31 1979		26. REGISTRAR'S SIGNATURE <u>Antony McCreary</u>	
6633 Old Alexander Ferry Rd Clinton, Md.							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 20697 REG. NO. 279460							
1. DECEASED NAME (TYPE OR PRINT)		FIRST ANDREW		MIDDLE S		LAST DONNELLY		2a. DATE OF DEATH MONTH DAY YEAR AUG 18 79	
3. SEX MALE		4. RACE CAUC		5. DATE OF BIRTH December 20 09 ⁸		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7b. HOUR PM 1200 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASS		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.			
10. CITY OR TOWN OF DEATH ANDREWS AIR FORCE BASE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MALCOLM GROW USAF MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ARMY RET		12b. KIND OF BUSINESS OR INDUSTRY Military	
13a. STATE DELAWARE		13b. COUNTY KENT		13c. CITY OR TOWN DOVER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 211 WINTERBERRY DR	
14. FATHER'S NAME FIRST MIDDLE LAST John				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Esche					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 1934-1957		17. INFORMANT MARGARET DONNELLY		ADDRESS 211 WINTERBERRY DR			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARDIAC ARREST 486- DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONIA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 HOURS 2 1/2 DAYS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) METASTATIC CARCINOMA									
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) NA		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 17 AUG 1979, to 18 AUG 1979, that (I) (we) last saw the deceased alive on 18 AUG 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Edward S Hanna DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED 19 AUG 79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD S HANNA, CAPT, USAF				22e. ADDRESS ANDREWS AIR FORCE BASE MD 20331					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/23/79		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Va.			
24. FUNERAL DIRECTOR NAME G.P. Kalas				ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR AUG 27 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 9 20698	
1. DECEASED NAME (TYPE OR PRINT) GEORGE MYRON DOWNS, Jr.						2a. DATE OF DEATH MONTH AUGUST DAY 7 YEAR 1979		2b. HOUR 1620P M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH JULY DAY 20 YEAR 1906		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE COUNTY MD.					
10. CITY OR TOWN OF DEATH BASE				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NAME IN SUCH FACILITY, GIVE STREET ADDRESS) ANDREWS AIR FORCE MALCOLM GROW MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CABLEMAN		12b. KIND OF BUSINESS OR INDUSTRY DC TRANSIT CO			
13a. STATE MD				13b. COUNTY DISTRICT HEIGHTS		13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 6012 PARKLAND CT #101			
14. FATHER'S NAME FIRST GEORGE MIDDLE MYRON LAST DOWNS (DEC)				15. MOTHER'S MAIDEN NAME FIRST NANCY MIDDLE MARIE LAST CHINN (DEC)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 578-10-6012		17. INFORMANT (WIFE) ADDRESS HELEN B DOWNS 6012 PARKLAND CT					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Myocardial Infarction (c) Atherosclerotic Cardiovascular Disease									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic Obstructive Pulmonary Disease											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Terry L. Angstedt				22c. DATE SIGNED 7 Aug 79				22d. PHYSICIAN'S NAME (TYPE OR PRINT) Terry L. Angstedt			
22e. ADDRESS MALCOLM GROW USAF MEDICAL CENTER ANDREWS AIR FORCE BASE, MARYLAND 20331											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8-11-79		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cem.		23d. LOCATION CITY OR TOWN Clinton, P.G., Md. COUNTY STATE			
24. FUNERAL DIRECTOR NAME Robt E Wilhelm ADDRESS 4308 Suitland Rd., Suitland, Md.				25a. DATE REC'D. BY REGISTRAR AUG 13 1979		25b. REGISTRAR'S SIGNATURE Anthony M. Brady					

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 20699	
1. DECEASED NAME (TYPE OR PRINT) Robert L. DUBE						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> AUG 23 1979		2b. HOUR 952 P			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 6 DAY 16 YEAR 1931		6. AGE (IN YEARS) LAST BIRTHDAY 48		IF UNDER 1 YR. MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN 0		7c. DATE PRONOUNCED DEAD AUG 23 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Hampshire		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIAGE STATUS WIDOWED <input type="checkbox"/> EVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.					
10. CITY OR TOWN OF DEATH Lanham		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Doctors' Hospital of Pr. Geo. Co.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY U.S. Army			
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Virginia 13b. COUNTY Grayson 13c. CITY OR TOWN Galax						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Box 27			
14. FATHER'S NAME FIRST Cyprien MIDDLE J. LAST Dube						15. MOTHER'S MAIDEN NAME FIRST Helen MIDDLE Osborne LAST Osborne		16. ADDRESS 2216 S. Quincy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. 001222539		17. INFORMANT Lawrence P. Dube-bro-St., Arl., Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Aspiration of gastric contents											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Augusto P. Rodriguez				TITLE (SPECIFY) Medical Examiner				DATE SIGNED 8-23-79			
EXAMINER'S NAME (TYPE OR PRINT) Augusto Rodriguez				ADDRESS 5009 Rydum Court, Camp Springs							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-28-1979		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN Arlington		23e. STATE Va.			
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.				25. DATE RECEIVED BY REGISTRAR AUG 29 1979		26. REGISTRAR'S SIGNATURE Robert McCreedy					
8434 Ga. Ave., S.S. Md.											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1900

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1900

1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonappers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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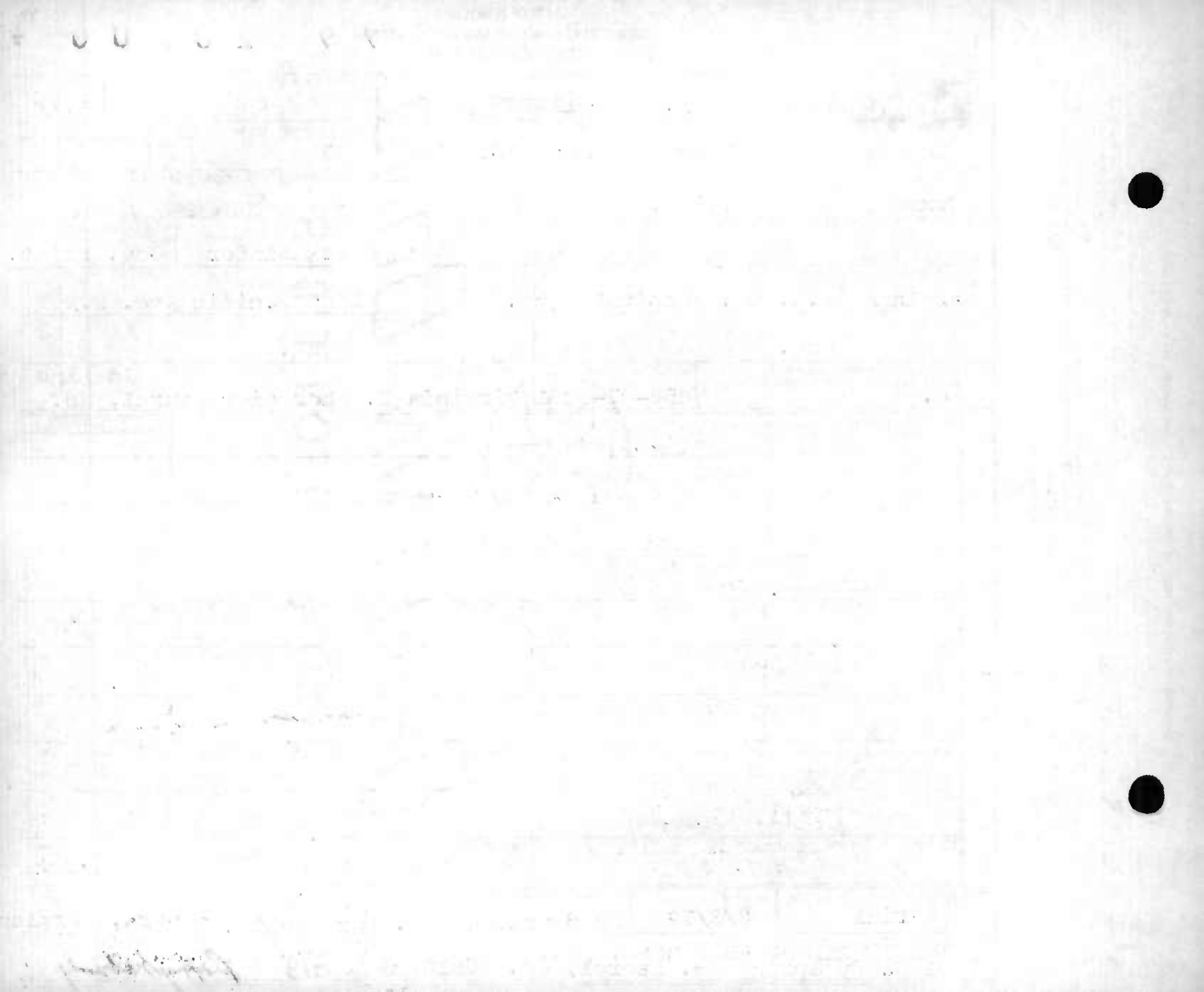
2400

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

9 20700

1. DECEASED NAME (TYPE OR PRINT) DULLNIG LEOLA M. DULLNIG			2a. DATE OF DEATH MONTH DAY YEAR August 1 1979			2b. HOUR 3:10 P M				
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 15, 1900		6 AGE (IN YEARS LAST BIRTHDAY) 79		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges Laurel, MD.				
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Laurel-Beltsville Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Book Binder		12b. KIND OF BUSINESS OR INDUSTRY Gov. Print.		
13a. STATE Maryland			13b. COUNTY P.G. Co.		13c. CITY OR TOWN Capital Hgts		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1605 Pacific Ave. S.E.	
14. FATHER'S NAME FIRST MIDDLE LAST Unk.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unk.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.			16b. SOCIAL SECURITY NO. 456-07-9061		17. INFORMANT ADDRESS 415 Old Line Av Virginia E. Obermeier Laurel, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) atrial fibrillation DUE TO, OR AS A CONSEQUENCE OF (c) massive CVA-									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes mellitus -										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 7-5- 19 79 , to 8-1- 19 79 , that (I) (we) lost saw the deceased alive on 8-1- 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Fallaford			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8-2-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G.A. DE LA TORRE					22e. ADDRESS 320 Montgomery St. Laurel, Md. 20801					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/3/79		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park Balto.			23d. LOCATION CITY OR TOWN COUNTY STATE Howard, Maryland		
24. FUNERAL DIRECTOR ELBCK LAUREL FUNERAL HOME, INC. 7601 Sandy Spring Rd. Laurel, Md. 20810					25a. DATE REC'D. BY REGISTRAR 8-3-1979			25b. REGISTRAR'S SIGNATURE P. J. K. K. K.		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 9 20701									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
CHARLES		E.		ECKLOFF				08 20 79		11:36A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
Male		Caucasian		07 24 12		67					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Washington, D.C.		USA				Prince Georges County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									
Clinton		Southern Maryland Hospital Center									
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Retired											
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. COUNTY		13d. CITY OR TOWN		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13f. STREET ADDRESS	
Md.		St. Marys		California				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 228	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Millard		Eckloff		Barbara		Stewart		No		216-34-5931	
				Louise A. Eckloff		California, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cadex - respiratory arrest</u>											
5723 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Potential hypertension & Bleeding</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>& emphysema lungs</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Gram - line Septicemia</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8-20-79</u> to <u>8-20-79</u> , that (I) (we) last saw the deceased alive on <u>8-20-79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
<u>J.S. Gull</u>		<u>J.S. Gull</u>				<u>8/20</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
<u>J.S. Gull</u>		<u>Southern Maryland Hospital, Clinton</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
<u>Burial</u>		<u>8/23/79</u>		<u>Trinity Memorial</u>		<u>Waldorf, Charles, Maryland</u>					
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR									
<u>W. Clarke Wittingley</u>		<u>8/23/79</u>									
		25b. REGISTRAR'S SIGNATURE									
		<u>Jonathan Md.</u>									

BP _____



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79

20702

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) JOHN EDNOCK			2a DATE OF DEATH MONTH DAY YEAR AUGUST 30, 1979			2b HOUR 4:15a M				
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Aug 30 1899		6 AGE (IN YEARS LAST BIRTHDAY) 80		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.				
10 CITY OR TOWN OF DEATH Lanham		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Magnolia Gardens Nursing Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b KIND OF BUSINESS OR INDUSTRY Const.		
13a STATE Maryland			13b COUNTY Pr. Geo.		13c CITY OR TOWN Bowie		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 12505 Chelton Lane	
14 FATHER'S NAME FIRST MIDDLE LAST Metro			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Figel							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			16b SOCIAL SECURITY NO. n/a		17 INFORMANT Richard J. Ednock		ADDRESS Same as # 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Swiss failure, pneumonia 1519 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) metastatic stomach cancer DUE TO, OR AS A CONSEQUENCE OF (c) cachexia								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from 7/19 , 19 79 , to 8/30 , 19 79 , that (1) was lost saw the deceased alive on 8/22 , 19 79 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (1) did did not view the body after death.										
22b. SIGNATURE Gillian Karantinos, M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Aug. 30, 1979		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gillian Karantinos, M.D.						22e. ADDRESS 3231 Superior La # A-6 Bowie, Md. 20715				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4 Sep 79		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Scranton, Pennsylvania			
24. FUNERAL DIRECTOR NAME Robert G. Beall Funeral Home						25a. DATE BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 4 1979				
25c. ADDRESS 9013 Annapolis Rd. Lanham, Md. 20801										

MEDICAL CERTIFICATION

29

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 9 20703							
1. DECEASED NAME (TYPE OR PRINT) DALE B. ELDRIDGE						2a. DATE OF DEATH MONTH DAY YEAR 08-18-79		2b. HOUR 7:30 P.M.	
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR June 9, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 74 years YRS.		7. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES COUNTY MD.			
10. CITY OR TOWN OF DEATH LAUREL, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER LAUREL BELTSVILLE HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Eng-Agriculture		12b. KIND OF BUSINESS OR INDUSTRY U S Government	
13a. STATE Md						13b. COUNTY Pro Georges		13c. CITY OR TOWN College Park	
14. FATHER'S NAME FIRST MIDDLE LAST Osa Eldredge						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Boyes			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217 36 8066A		17. INFORMANT ADDRESS Wilma Eldredge College Park, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE 4140 DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY HEART DISEASE. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6-30-19-79 to 8-18-19-79, that (I) (we) lost saw the deceased alive on 8-18-19-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (Do not check and not view the body after death.)									
22b. SIGNATURE <i>M. H. Chaudhry</i> MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8-19-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. H. CHAUDHRY MD				22e. ADDRESS 3450 FT. MEAD Rd. Laurel Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug 22, 1979		23c. NAME OF CEMETERY OR CREMATORY Tedrow Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Wauseon Fulton Ohio			
24. FUNERAL DIRECTOR NAME F. Gasch's Sons P A Hyattsville, Md.				25a. DATE REC'D. BY REGISTRAR AUG 21 1979		25b. REGISTRAR'S SIGNATURE <i>W. J. McCreedy</i>			

00100

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

3



Date	Time	Location	Activity	Remarks
10-1-73	10:00 AM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	11:00 AM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	12:00 PM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	1:00 PM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	2:00 PM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	3:00 PM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	4:00 PM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	5:00 PM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	6:00 PM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	7:00 PM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	8:00 PM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	9:00 PM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	10:00 PM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	11:00 PM	FBI - New York	Interview	J. Edgar Hoover

CHRONOLOGICAL LIST
OF THE
INTERVIEWS
CONDUCTED
ON
OCTOBER 1, 1973

Date	Time	Location	Activity	Remarks
10-1-73	10:00 AM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	11:00 AM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	12:00 PM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	1:00 PM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	2:00 PM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	3:00 PM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	4:00 PM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	5:00 PM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	6:00 PM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	7:00 PM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	8:00 PM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	9:00 PM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	10:00 PM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	11:00 PM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	12:00 AM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	1:00 AM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	2:00 AM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	3:00 AM	FBI - New York	Interview	J. Edgar Hoover
10-1-73	4:00 AM	FBI - New York	Interview	J. Edgar Hoover

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 3 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR 15 ME (5))
15M 7/76

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20704

1. FOR STATE REGISTRAR		26. DATE KNOWN OF DEATH		27. DATE		28. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		26. DATE KNOWN OF DEATH		27. DATE		28. HOUR	
LORAE M. ELLIS		8 1 19 79		8 1 19 79		11:05 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. BALTIMORE CITY OR COUNTY OF DEATH	10. KIND OF BUSINESS OR INDUSTRY
female	negro	JULY 25, 1943	36 YRS.			Prince George's County	AT HOME
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH				
VIRGINIA	U.S.A.	XX NEVER MARRIED	Prince George's County				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				
Cheverly	Prince George's Gen. Hosp.	HOUSEWIFE	AT HOME				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
D.C.	NONE	WASHINGTON	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	501 LEBAUM ST. S.E.			
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME						
WILLIAM E. CASHWELL SR.	ELIZABETH SMITH						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS				
NO	579-84-7635	RONALD ELLIS	437 MELLON ST. S.E. WASH. D.C.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I DEATH WAS CAUSED BY: Multiple gunshot wounds							
IMMEDIATE CAUSE (a) 9654							
DUE TO, OR AS A CONSEQUENCE OF							
(b)							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?					
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
	7 P.M. 7-30-19 79	Shot by police.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION					
	road	Rt. 5 & St. Barnabas Rd. Prince George's Md					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
TITLE (SPECIFY) Assistant MEDICAL EXAMINER							
DATE SIGNED 8-2-79							
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.							
ADDRESS 111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION				
BURIAL	8-7-1979	HARMONY MEMORIAL PARK	LANDOVER P.G.C. Md.				
24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE					
W. W. CHAMBERS CO. 517 11th ST. S.E. WASH.	AUG 09 1979	[Signature]					

10704

THE UNITED STATES OF AMERICA
DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

JULY 22, 1943

VIRGINIA

U.S.A.

ROCKFORD

41 201 LINDEN ST. N.E.

2002

D.C.

SMITH

ALLABACH

CASHWELL ST.

VIRGINIA

375-84-7025

ROCKFORD

407 HILLMAN ST. N.E.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 20705	
1- FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
MARGARET F. FIELDS						08 05 79			9:11 AM		
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
F		B		10-4-1887		91 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
MD.		U. S. A.				PRINCE GEORGE'S COUNTY MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
CHEVERLY		PRINCE GEORGE'S GENERAL HOSPITAL				DOMESTIC		CHAR			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
			MD.			P. G.			NEW CARROLLTON		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
HENRY ROBINSON			SARAH WILLIAMS						7731 RIVERDALE RD.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17 INFORMANT ADDRESS					
No			519-50-0288A			GWENDOLYN JOHNSON - SAME AS #13 ABOVE					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Cardio Respiratory Arrest.											
4140											
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC & HYPERTENSIVE HEART 15-20 YRS.											
DUE TO, OR AS A CONSEQUENCE OF (c) RENAL FAILURE.										one year.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7-19-79 to 8-15-1979, that (I) (we) lost the deceased alive on 8-15-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
A. Q. ADRI			M.B.A.S.						8-16-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
S. ASIF QADRI MD.			1-HOSPITAL DR. CHEVERLY MD.								
23a. BURIAL CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
			8-9-79		HARMONY MEM. CEM.		HIGHLAND PARK P.G. MD.				
24 FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
H.S. WASHINGTON & SONS			4925 BURROUGHS AVE. N.E.			AUG 13 1979		Anthony McBrady			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE JUDICIAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										20106 REG. NO.	
1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Vernon E. FLETCHER										2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> 8-10 1979	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> 8-1-22		6. AGE (IN YEARS) (LAST BIRTHDAY) <input checked="" type="checkbox"/> YRS. 57		IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> 8-10 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD.	
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Gen'l Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Marble Mason		12b. KIND OF BUSINESS OR INDUSTRY Construction	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland				13b. COUNTY Pr. Geo's		13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6304 Sheridan Street	
14. FATHER'S NAME FIRST William MIDDLE Ashby LAST Fletcher						15. MOTHER'S MAIDEN NAME FIRST Pauline MIDDLE E. LAST GRAY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. 11944-45		17. INFORMANT ADDRESS Same as blk 13e Michael and Gerald Fletchers (Sons)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4029 Hypertensive Cardiovascular disease IMMEDIATE CAUSE (a) Hypertensive Cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE August P. Rodriguez				TITLE (SPECIFY) M.D.				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) August P. Rodriguez				ADDRESS 5009 Rayburn Court, Camp Spring							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8/15/79		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery				23d. LOCATION CITY OR TOWN Brentwood Pr. Geo's Md. COUNTY Pr. Geo's STATE Md.	
24. FUNERAL DIRECTOR NAME Francis Gasch's Sons, PA ADDRESS Hyattsville, Md.				25a. DATE REC'D BY REGISTRAR AUG 16 1979				25b. REGISTRAR'S SIGNATURE [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 20707							
1 DECEASED NAME (TYPE OR PRINT)		FIRST BRADLEY		MIDDLE MELVIN M.		LAST FREEMAN		2a. DATE OF DEATH MONTH DAY YEAR 08 08 79	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 11 08 58		6 AGE (IN YEARS LAST BIRTHDAY) 20		2b. HOUR 11:30P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Prince Georges		10 MONTHS 11 12 13 14 15 16 17 18 19 20 21 22 23 24 HRS. 01 02 03 04 05 06 07 08 09 10 11 12	
10 CITY OR TOWN OF DEATH Clinton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Southern Maryland Hospital Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Warehouse Emp.		12b. KIND OF BUSINESS OR INDUSTRY Safeway Co.	
13a. STATE Md.		13b. COUNTY Pr. George		13c. CITY OR TOWN Brandywine		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 70 McKendree Road	
14 FATHER'S NAME FIRST MIDDLE LAST William E. Freeman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rheda A. Shovestull		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219-72-7809		17. INFORMANT ADDRESS Rheda A. Freeman same as 13	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE LYMPHOBLASTIC LEUKEMIA 2040 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SEVERE DISSEMINATED INTRAVASCULAR COAGULATIONS. (c) ACUTE PANCREATITIS								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS. DAYS. DAYS.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) LEUKEMIC KIDNEY WITH HEMATURIA. RETROPERITONEAL HEMORRHAGE.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IE EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8-5-79, 1979, to AUG. 8, 1979, that (I) (we) lost saw the deceased alive on Aug. 8, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Peter W. Yim						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED AUG 08 9'79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER W. YIM M.D.						22e. ADDRESS 7900 OLD BRANCH AVE. CLINTON, MARYLAND 20735			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-11-79		23c. NAME OF CEMETERY OR CREMATORY Trinity Mem. Garden		23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf, Charles, Md.			
24. FUNERAL DIRECTOR NAME Huntt Funeral Home						ADDRESS Waldorf, Maryland		25a. DATE REC'D. BY REGISTRAR AUG 15 1979	
						25b. REGISTRAR'S SIGNATURE [Signature]			

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										20708 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Wilmer Samuel FRYE							2a. DATE KNOWN OF DEATH ESTIMATED 8-22-79		2b. HOUR 1206		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9-10-1959		6. AGE (IN YEARS LAST BIRTHDAY) 19 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED MONTH DAY YEAR 8-22-79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George MD.		
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince Georges General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Florist			12b. KIND OF BUSINESS OR INDUSTRY Flowers	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland			13b. COUNTY PG			13c. CITY OR TOWN Seat Pleasant			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Samuel A. Frye						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mildred I. Lacy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 1944-1946		17. INFORMANT 7294 Pimms Lane Lawrence Frye Lanham, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Augusto P. Rodriguez				TITLE (SPECIFY) Medical Examiner				DATE SIGNED 8-22-79			
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez				ADDRESS 5029 Rayburn Court, Camp Springs, Md 20746							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 25 Aug. 1979		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland		
24. FUNERAL DIRECTOR NAME Robert G Beall Funeral Home				ADDRESS 9013 Annapolis Rd. Lanham, Maryland		25a. DATE REC'D. BY REGISTRAR AUG 29 1979			25b. REGISTRAR'S SIGNATURE Robert G Beall		

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (5))
15M 7/76

3100



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M
(VRA 15, 4) 7/78

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Essie - GAITHER			2a. DATE OF DEATH MONTH DAY YEAR August 31, 1979			2b. HOUR 3:35			P M		
3. SEX Female			4. RACE Black			5. DATE OF BIRTH MONTH DAY YEAR 10 30 1906			6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 'SIC.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Prince George County MD.		
10. CITY OR TOWN OF DEATH Glenn Dale			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Glenn Dale Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C.			13b. CITY OR TOWN Wash.			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. STREET ADDRESS 534 Col. Rd. N.W.		
14. FATHER'S NAME FIRST MIDDLE LAST John Goodgette			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unkown			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. Not Stated		
17. INFORMANT ADDRESS Ardie Bullock Sister S.A.A.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident, recurrent			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks					
436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension			years					
			DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus; cerebrovascular accident with right hemiplegia											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 9, 1979 , to August 31, 1979 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 31, 1979 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.											
22b. SIGNATURE James W. Wills M.D.			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED August 31, 1979		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James W. Wills, M.D.			22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland 20769								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-6-79			23c. NAME OF CEMETERY OR CREMATORY Washington Nat'l			23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md.		
24. FUNERAL DIRECTOR NAME Frazier			ADDRESS Home 389 R.I. Ave			25a. DATE REC'D. BY REGISTRAR SEP 10 1979			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR		9 20710											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
Laura J. Dates								August 27 1979		12:25 PM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
Female		White		July 25 1987		92 YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Delaware		U.S.				Prince Georges MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)											
Lanham, Md		Mazonic Daedens Nursing Home											
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Ret. Cashier-Phila.		Transportation Company											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Virginia		Fairfax		Vienna				1116-Moorefield Creek, Rd., S.W.					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
James Burton Jones		Mary Porter											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS									
No		166-07-8813 A		Maryann D.B. Lee (Granddaughter) Same as #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 449 Arteriosclerosis thrombotic										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic artery disease										1 hr			
DUE TO, OR AS A CONSEQUENCE OF (c)										1 yr			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		P.M. 19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 8/27 1979, to 8/27 1979, that (I) (we) lost saw the deceased alive on 8/27 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) make the body offer death.													
22b. SIGNATURE DEGREE										22c. DATE SIGNED			
Leon R. Levitzky M.D.										August 27, 1979			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS			
Leon R. Levitzky M.D.										3708 Rhode Island Ave. Mt. Rainier Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Cremation		Aug. 27, 1979		Lee's Crematory		Washington, D.C.							
24. FUNERAL DIRECTOR J. Wm. Lee's Sons Co. 300-4th St., NE, Wash DC 20002										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
										SEP 10 1979		P. J. McCarty	

1. M. Lee's Sons Co. 300-4th St., NE, Wash., DC
Washington, D.C.

Operation
Mar. 27, 1947 Lee's Crematory

166-CY-881 A Maryann D.B. Lee (Grandmother) Same as 13

James Burton Jones Mary

Virginia Fairfax Vienna xx 1116-Monrovia Green, W.D., R.W.

Net. Cashier - Phila. Transp. Co.
Company

White

1.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79 20711

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE	LAST		
WILLIAM J M GEE		08		15	79		11 A M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male	Black	MONTH DAY YEAR Nov. 11, 1935		43		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. MD.	
S.C.	USA			PRINCE GEORGES			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
CHEVERLY	PRINCE GEORGES GENERAL HOSPITAL		Disabled-None				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
13a. STATE 13b. COUNTY		YES <input type="checkbox"/> NO <input type="checkbox"/>		4903 Ayers Place, S.E.			
Washington, D.C.							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST		FIRST MIDDLE LAST					
William Gee		Phyllis Hamm					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Arrest</u> 5679 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Stroke</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>Pneumonia, GI bleeding</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8-21</u> , 19 <u>79</u> , to <u>8-15</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>8-15</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>Joseph Colella</u>		MD				8/15/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
JOSEPH COLELLA M.D.		PGGH/MC, CHEVERLY, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		8/21/79		Maryland National		Laurel, Maryland	
24. FUNERAL DIRECTOR NAME		25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Stewart		NE 8/20/79		<u>John H. Stewart</u>			
Funeral Home-4001 Benning Road							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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2.6 with note

Y1974243

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH20712
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Barbara Leslie Gilman			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 8 19 79			2b. HOUR M 8:40 P.M.
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR May 9, 1961	6. AGE (IN YEARS) LAST BIRTHDAY YRS. 18	IF UNDER 1 YR. MONTHS DAYS HOURS MIN 18	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN 18	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 19 79
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) District of Columbia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George County MD.
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY Pr. Geo's Community College
13a. STATE Md.			13b. COUNTY Pr. Geo's	13c. CITY OR TOWN Upper	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 14818 Chelsea Lane
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Newell Gilman			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily -- Wyvill			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. ---		17. INFORMANT Arthur N. Gilman - Upper Marlboro, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. 8120 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20870:
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR 7:18 P.M. 8/19 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver in auto/auto collision		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt#202/1/2 Mi South Rt#556, PG Co. MD		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .						
ACTUAL SIGNATURE H. Guard		M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 8/20/79
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.		ADDRESS 111 Penn Street, Balto., MD 21201				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/23/79.		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery Clinton (Pr. Geo's) Md.		23d. LOCATION CITY OR TOWN COUNTY STATE Pr. Geo's Md.
24. FUNERAL DIRECTOR NAME Richard A. Coleman		ADDRESS Upper Marlboro, Maryland 20870		25a. DATE REC'D. BY REGISTRAR SEP 4 1979		25b. REGISTRAR'S SIGNATURE Jeffrey McBrady

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, IN THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP



May 2, 1911

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DHMH - 17
(VR A15 ME (S))
15M 7/76

STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		20713	
FOR STATE REGISTRAR		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		2b. HOUR	
Charles Theodore GOFORTH		8-20 1979		M	
3. SEX		4. RACE		5. DATE OF BIRTH	
Male		White		11-22-33	
6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.	
45 YRS.		MONTHS DAYS HOURS MIN.		DOA	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		10. CITIZEN OF WHAT COUNTRY?		11. MARRIED	
Mississippi		U.S.A.		NEVER MARRIED	
12. CITY OR TOWN OF DEATH		13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
U.S.A.		(D.O.A.) Malcolm Grow A.A.F.B.		Principals	
15. STATE		16. COUNTY		17. CITY OR TOWN	
Md.		P.G.		Upper Marlboro	
18. FATHER'S NAME		19. MOTHER'S MAIDEN NAME		20. STREET ADDRESS	
Charles T. Godorth Sr.		Lila M. Honnoll		11810 Fairgreen Lane	
21. WAS DECEASED EVER IN U.S. ARMED FORCES?		22. SOCIAL SECURITY NO.		23. INFORMANT	
Yes		428-52-4524		Jane M. Goforth Same as #13	
24. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c))		25. IMMEDIATE CAUSE (a)		26. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4292		Coronary atherosclerotic cardiovascular disease			
27. PART 1 DEATH WAS CAUSED BY:		28. DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)			
		(c)			
29. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
30. DATE OF OPERATION		31. CONDITION FOR WHICH OPERATION WAS PERFORMED?		32. AUTOPSY?	
				YES NO	
33. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		34. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		35. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
36. INJURY OCCURRED WHILE AT WORK		37. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		38. LOCATION CITY OR TOWN COUNTY STATE	
NOT WHILE AT WORK					
39. I certify that I took charge of the remains described above, held an autopsy, inspection, inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.					
40. ACTUAL SIGNATURE		41. TITLE (SPECIFY)		42. DATE SIGNED	
Augusto P. Rodriguez		Deputy		8-21-79	
43. EXAMINER'S NAME (TYPE OR PRINT)		44. ADDRESS		45. MEDICAL EXAMINER	
Augusto P. Rodriguez, M.D.		5009 Rayburn Ct., Camp Springs, Md. 20033			
46. BURIAL, CREMATION, REMOVAL (SPECIFY)		47. DATE		48. NAME OF CEMETERY OR CREMATORY	
Burial		8/23/79		Eggers Cemetery	
49. LOCATION CITY OR TOWN		50. COUNTY		51. STATE	
Caledonia		Lowndes		Miss.	
52. DATE REC'D. BY REGISTRAR		53. REGISTRAR'S SIGNATURE		54. ADDRESS	
AUG 24 1979		Ricky K. Bailey			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20714

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ABRAHAM (ABE) GOLDBERG			2a. DATE OF DEATH MONTH DAY YEAR 8.2.79			2b. HOUR 6.20 P M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 9 23 1918		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PROPIETOR		12b. KIND OF BUSINESS OR INDUSTRY HOME FURNISHINGS	
13a. STATE MARYLAND					13b. CITY OR TOWN SILVER SPRING		13c. STREET ADDRESS 1314 MIDWOOD PLACE		
14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN GOLDBERG		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SADIE GORDON			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW II				
16a. SOCIAL SECURITY NO. 079-16-7490		17. INFORMANT ADDRESS ROSE GOLDBERG, wife, SAME AS No. 13							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a):

CARDIOGENIC**SHOCK**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**410-**Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b):

ACUTE**MI**

DUE TO, OR AS A CONSEQUENCE OF

(c):

CAD

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

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MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 8-2 , 19 79 , to 8-2 , 19 79 , that (I) was lost saw the deceased alive on 8/2 , 19 79 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was did not view the body after death.							
22b. SIGNATURE Lawrence Satin M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-2-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAWRENCE SATIN, M.D.				22e. ADDRESS 5711 SARVIS AVENUE, RIVERDALE, MARYLAND			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/5/1979		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN		23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH VIRGINIA	
24. FUNERAL DIRECTOR NAME DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME ADDRESS 232 CARROLL STREET, N.W., WASHINGTON, D.C.				25a. DATE REC'D. BY REGISTRAR AUG 7 1979		25b. REGISTRAR'S SIGNATURE <i>Anthony M. [Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		79 20715 REG. NO.	
1. DECEASED NAME (FIRST, MIDDLE, LAST) HELEN Gisriel GREGORY		2a. DATE OF DEATH (MONTH, DAY, YEAR) AUGUST 27, 1979		2b. HOUR 7:10A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH (MONTH, DAY, YEAR) May 22, 1909	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS, LAST BIRTHDAY) 70 YRS.	
10. CITY OR TOWN OF DEATH CHEVERLY, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GEN. HOSP.		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Cheverly	
14. FATHER'S NAME (FIRST, MIDDLE, LAST) Ferdinand A. Gisriel		15. MOTHER'S MAIDEN NAME (FIRST, MIDDLE, LAST) Catherine Boylan		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-10-1789		17. INFORMANT Katherine Welti	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1991 Metastatic Cancer IMMEDIATE CAUSE (a) Metastatic Cancer DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION 8-27		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 19		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 8-27 , 19 79 , to 8-27 , 19 79 , that (we) last saw the deceased alive on 8/27 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.					
22b. SIGNATURE Barry Epstein		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-27	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry Epstein M.D.		22e. ADDRESS Cheverly, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-29-79		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Bryantown Chas. Md.		25a. DATE REG'D. BY REGISTRAR AUG 31 1979			
24. FUNERAL DIRECTOR NAME Huntt Funeral Home		ADDRESS Waldorf, Md.		25b. REGISTRAR'S SIGNATURE Barry Epstein	

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>May Elizabeth Gregory</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>8/12/79</i>		2b. HOUR <i>9:49 AM</i>	
3. SEX <i>Female</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>4 15 90</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>82</i> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>North Carolina</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince George</i> MD.	
10. CITY OR TOWN OF DEATH <i>Clinton</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Southview MD Hosp. Center</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Clerical (R)</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Peoples Drug Store</i>
13a. STATE <i>Virginia</i>	13b. COUNTY <i>Prince William</i>	13c. CITY OR TOWN <i>Woodbridge</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <i>13902 Rope Dr. Woodbridge, VA</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles Hooten</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Patricia Saddler</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>577-12-1909</i>		17. INFORMANT ADDRESS <i>Mr. Raymond S. Gregory 13902 Rope Drive</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4140</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <i>upper respiratory infection</i> DUE TO, OR AS A CONSEQUENCE OF <i>ASPD</i> (c) <i>terminal decelerate rule</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>82 years old w/ chronic emphysema</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>MD HSS R</i>		DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Aug 15, 1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Stafford Memorial Pk.</i>	
23d. LOCATION CITY OR TOWN <i>Stafford, Virginia</i>		COUNTY <i>Stafford</i>		STATE <i>VA</i>	
24. FUNERAL HOME <i>Mountcastle</i>		25a. DATE REC'D. BY REGISTRAR <i>AUG 16 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Rotary McCreedy</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR 1- STATE REGISTRAR										8/27/79 Kan STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										20717 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Rex Gerald GREGORY										2a. DATE KNOWN OF DEATH ESTIMATED 8-23 1979					2b. HOUR 10						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8-8-07		6. AGE (IN YEARS) LAST BIRTHDAY 72 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 8-23 1979		7d. HOUR 10		7e. MINUTE 10							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.									
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pressman, Ret.				12b. KIND OF BUSINESS OR INDUSTRY Merkle Press									
13a. STATE Maryland				13b. COUNTY Prince Geo		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4209 Jefferson Street											
14. FATHER'S NAME FIRST MIDDLE LAST William B. Gregory						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Unknown Hollister															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579 03 8452		17. INFORMANT Judith M. Shifflett Alexandria, Va.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8 P.M. 8-23 1979				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Choked on poorly chewed food bolus													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4209 Jefferson Street, Hyattsville, P. George, Md													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE Augusto P. Rodriguez				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER				DATE SIGNED 8/23/79									
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez				ADDRESS 3209 Rayburn Court, Camp Springs Md 20746																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8/28/79		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P. George Md.											
24. FUNERAL DIRECTOR Francis Gasch's sons Funeral Home, P.A.										25a. DATE RECEIVED BY REGISTRAR AUG 27 1979		25b. REGISTRAR'S SIGNATURE Harvey M. Brady									
26. BY Hyattsville, Md.																					

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 20718

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHRISTINE M. GRIFFITHS			2a. DATE OF DEATH MONTH DAY YEAR 08 18 79			2b. HOUR 7:22 AM		
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Apr. 23, 1917		6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) No. Carolina		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.		
10 CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
12b KIND OF BUSINESS OR INDUSTRY								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Forestville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS 3733 Donnell Drive, #203								
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Creed				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Hicks				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 237-26-2778		17 INFORMANT ADDRESS Same as Above David J. Griffiths, Husband,				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CERBRAL VASCULAR ACCIDENT 436- DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MASSIVE LEFT CEREBRAL HEMISPHERE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from Aug. 16, 19 79, to 8/18/19 79, that (I) last saw the deceased alive on 8-17, 19 79, and that in (my) (the) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.								
22b. SIGNATURE Lawrence Satin				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-20-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-22-79		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G., Md.		
24 FUNERAL DIRECTOR NAME Robt E Wilhelm Funeral Home Rd., Suitland, Md.				25a. DATE REC'D. BY REGISTRAR AUG 24 1979				
25b. REGISTRAR'S SIGNATURE [Signature]								

8-20-77

DATE: 8-20-77

PRINCE GEORGE'S HOSPITAL

PRINCE GEORGE'S HOSPITAL

ACUTE CERVICAL VASCULAR ACCIDENT

ACUTE PASSIVE LEFT CERVICAL HYPERTENSION

HYPERTENSION

8-20-77

James M. M.D.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Ida V. Hanson			2a. DATE OF DEATH MONTH DAY YEAR 8 31 79			2b. HOUR 6.33 P.M.				
3. SEX F.		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 9 1896		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH P/G.				
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4013 Nicholson St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -		
13a. STATE Md.			13b. CITY OR TOWN PG Hyatts.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 4013 Nicholson Street			
14. FATHER'S NAME FIRST MIDDLE LAST Mildred Fairfax			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucinda Scates							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579 14 3993		17. INFORMANT Glenn C. Hanson (Son)				ADDRESS Same as above	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Resp and Cardiac arrest.</u> 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Metastasis Cancer.</u> (c) <u>Malnutrition.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 25 1978</u> to <u>Aug 31 1979</u> , that (I) (we) last saw the deceased alive on <u>7/13 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>Smith S. Ho M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/31/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SMITH S. HO M.D.				22e. ADDRESS 8323 Haddon Dr. Takoma Park Md. 20012			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/4/79		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md.				25a. DATE REC'D. BY REGISTRAR SEP 5 1979		25b. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate must be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Herzog und Herzogin
Materie der
Materie der



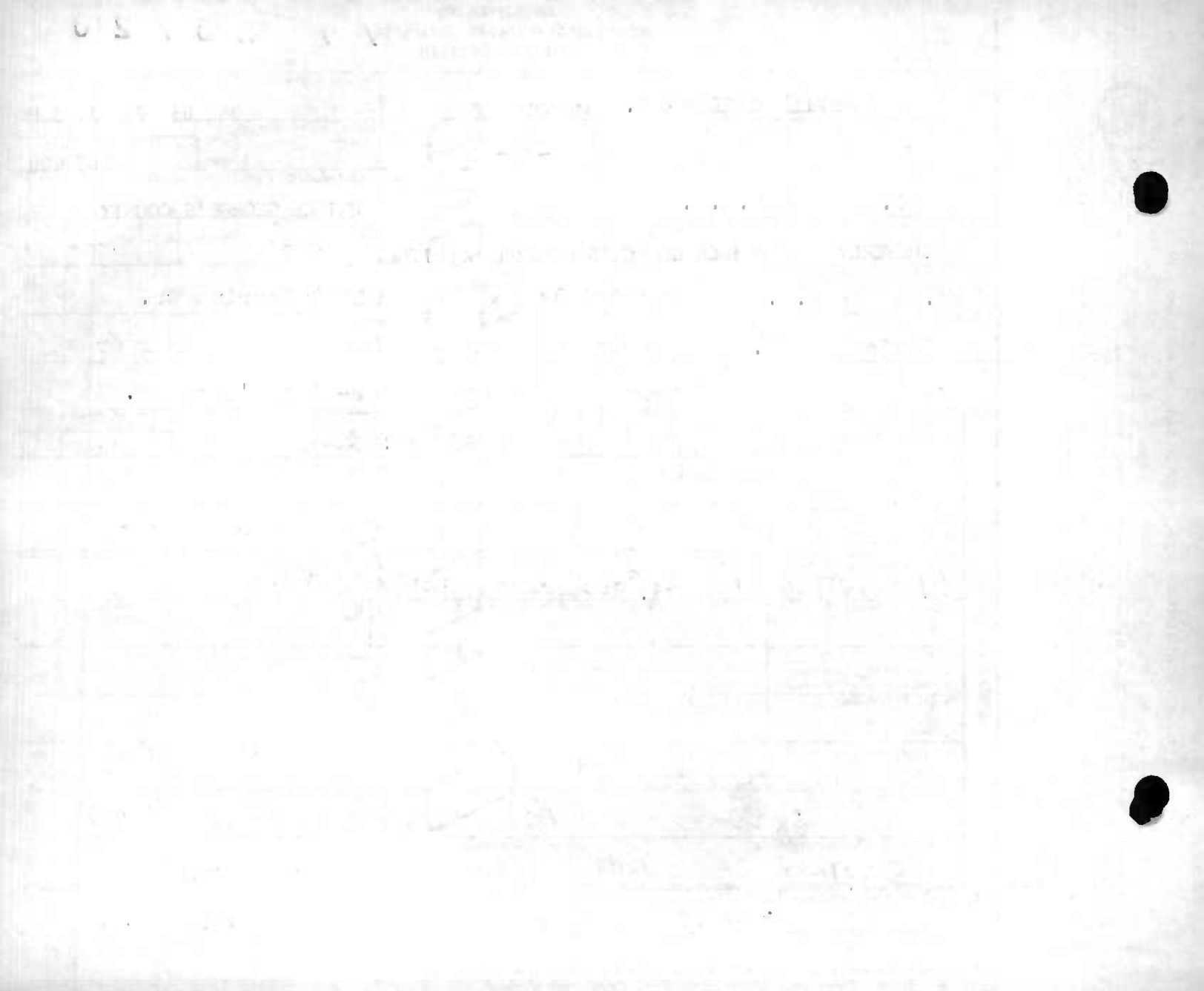
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/73
(VRA 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 9 20720							
I. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST (FEMALE) CARLENE S. HARPER					2a. DATE OF DEATH MONTH DAY YEAR 08 05 79			2b. HOUR 1:03 PM	
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 8-5-1979		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 03 09		IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE'S COUNTY MD.			
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PRINCE GEORGE'S GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY None	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. CITY OR TOWN P.G.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 2714 Lorrington Dr.			
14. FATHER'S NAME FIRST MIDDLE LAST Louis C. Gramby					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myra Harper				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT ADDRESS Geneva Harper-9311 D'Arcy Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHYXIA NEONATORUM 7689 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 HRS.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) PREMATURE, HYPOVOLAEMIA, PALLIDUS JUNCTIO									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/5, 1979, to 8/5, 1979, that (I) (we) lost saw the deceased alive on 8/5, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE S. WYNNE		DEGREE MD		22c. DATE SIGNED 8/5/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. WYNNE		22e. ADDRESS PRINCE GEORGE'S GENL HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 8-11-79		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND P.G. MD.			
24. FUNERAL DIRECTOR NAME H.S. WASHINGTON & SONS 4925 BURROUGHS AVE. N.E.				25a. DATE RECEIVED BY REGISTRAR AUG 15 1979		25b. REGISTRAR'S SIGNATURE [Signature]			



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 20721

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Margaret LORETTA Harper			2a. DATE OF DEATH MONTH DAY YEAR 8 11 79			2b. HOUR 7:45 AM				
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 25, 1886		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGES MD.				
10. CITY OR TOWN OF DEATH HYATTSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL MANOR				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY U.S. TREASURY		
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN KENSINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9629 CULVER STREET	
14. FATHER'S NAME FIRST MIDDLE LAST RICHARD McGRATH					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATHRYN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 213-40-7628		17. INFORMANT ADDRESS MARY E. FULNER SAME AS 13 DAUGHTER					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Regarded Minor Cerebrovascular Incident 436- DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Generalized Arteriosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 Mths 10 yrs 20 yrs										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Arteriosclerotic Heart Disease, Atrial Fibrillation; Paralysis Agitante										
19a. DATE OF OPERATION August 10, 1979			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Arteriosclerotic Heart Disease, Atrial Fibrillation; Paralysis Agitante			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (i) this hospital attended the deceased from June 19, 1974 to August 11, 1979 , that (ii) we lost saw the deceased alive on August 10, 1979 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death)										
22b. SIGNATURE John G. Nasou, MD						DEGREE MD		22c. DATE SIGNED 8-11-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John G. Nasou, MD						22e. ADDRESS 800 BERSHAW DR. SILVER SPRING, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8/13/79		23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR AUG 15 1979		25b. REGISTRAR'S SIGNATURE John G. Nasou		
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901										

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

500 UNIV. BLVD., W., SILVER SPRING, D. C. 20910

FRANCIS J. COLLINS

8/12/79

BOOK ORDER CERTIFICATION

WASHINGTON, D. C.

1-10-79

1-10-79

1-10-79

1-10-79

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1-10-79

1-10-79

1-10-79

NO

213-40-7822

WALTER E. FOLMER

STATE AS IS PAID

RICHARD

MORRIS

KATHRYN

MARYLAND

MONTGOMERY

KENNESAW

X

9629 CULVER STREET

WYATTSVILLE

CARROLL MARY

CLERK

U.S. TREASURY

WASHINGTON, D.C.

U.S.A.

X

PRINCE GEORGES

WHITE

JULY 22, 1988

93

LORETTA

1-10-79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 20722			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Mildred B. Hartman				2a. DATE OF DEATH MONTH August DAY 9 YEAR 1979		2b. HOUR 1:40 P M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH Mar. DAY 17 YEAR 1898		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD.	
10 CITY OR TOWN OF DEATH Suitland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5216 Silver Hill Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Suitland		13e. STREET ADDRESS 5216 Silver Hill Road	
14 FATHER'S NAME FIRST George MIDDLE M. LAST Hardy				15. MOTHER'S MAIDEN NAME FIRST Evie MIDDLE Lee LAST Lee			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Catherine Beall, Daughter			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) Carcinoma of Breast with chest metastases DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1970 , 19____, to Aug 9 , 19 79 , that (I) have lost saw the deceased alive on Aug 6 , 19 79 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) we did not view the body after death.							
22b. SIGNATURE John F. Shay				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-10-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. John F. Shay				22e. ADDRESS Suitland, Md. 5509 Old Silver Hill Rd.,			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-13-79		23c. NAME OF CEMETERY OR CREMATORY Epiphany Ch. Cem.		23d. LOCATION CITY OR TOWN Forestville, Md. COUNTY STATE	
24. FUNERAL DIRECTOR NAME Robt E Wilhelm ADDRESS 4308 Suitland				25a. DATE REC'D. BY REGISTRAR AUG 15 1979		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
Funeral Home Rd., Suitland, Md.							



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Handwritten text, possibly a date or initials, located in the lower left quadrant.

Handwritten text, possibly a date or initials, located in the lower center.

Handwritten text, possibly a signature or name, located in the lower right quadrant.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 20723 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Mary J. Hebble					2a. DATE OF DEATH MONTH DAY YEAR August 22, 1979			2b. HOUR P M 10:40	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 6, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Pr. Geo. Co. MD.			
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pr. Geo. Gen. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. R.N.		12b. KIND OF BUSINESS OR INDUSTRY Nursing	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4903 66th. Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST Michael Campbell					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Cusick				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-36-2145		17. INFORMANT ADDRESS 308 Forest Dr. Chester M. Hebble R.D.#1 Gettysburg, Pa.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 0389 Thrombotic thrombocytopenic purpura DUE TO, OR AS A CONSEQUENCE OF (b) Acute Renal Failure DUE TO, OR AS A CONSEQUENCE OF (c) Septicemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 weeks 2 weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8-15 , 19 72 , to 8-22 , 19 79 , that (I) (we) last saw the deceased alive on 8-22 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Channes Sahakian					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-23-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ohannes Sahakian, M.D.					22e. ADDRESS 6001 Landover Rd. Cheverly, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-25-79		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS F. Gasch's Sons F.H. P.A. Hyattsville, Md.					25a. DATE REC'D. BY REGISTRAR AUG 27 1979		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

MEDICAL CERTIFICATION

3801

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U.S. GOVERNMENT

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9. *Journal of the American Medical Association*, 1990; 263: 1025-1028.

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References

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• 209707 • 605

019-78-2147, Chester W. Cobble P.O. Box 1, Colmar, Pa.

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5. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840.

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1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | |
|--|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
ELIZABETH L. HEDLUND | | 2a. DATE OF DEATH
08 25 79 8:00A.M. | |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
12TH 13^{AY} 90^{YEAR} | 6. AGE (IN YEARS LAST BIRTHDAY)
88 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Germany | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince Georges |
| 10. CITY OR TOWN OF DEATH
Clinton | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
Southern Maryland Hospital Center | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
Pr. George | 13c. CITY OR TOWN
Mitchellville |
| 14. FATHER'S NAME
FIRST
Celestine
MIDDLE
Langner
LAST
Unknown | | 15. MOTHER'S MAIDEN NAME
FIRST
Unknown
MIDDLE
Unknown
LAST
Unknown | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
324-01-5750-D | 17. INFORMANT
ADDRESS
Church, Va.
Wilma E. Hurley, 2351 Mallory Ct., Falls | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
4148
IMMEDIATE CAUSE (a) Coronary Heart Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Pulmonary edema,
DUE TO, OR AS A CONSEQUENCE OF
(c) Myocardial Ischemia | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET
CITY OR TOWN
COUNTY
STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-17 , 19 79 , to 8-25 , 19 79 , that (I) (we) lost
saw the deceased alive on 8-24 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
[Signature] | DEGREE
MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED
8-25/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CIRLO A. MONTANEZ | 22e. ADDRESS
3308 Dodge PK Rd. - Landover Md | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
8/28/79 | 23c. NAME OF CEMETERY OR CREMATORY
Fairfax Memorial Park | 23d. LOCATION
CITY OR TOWN
COUNTY
STATE
Fairfax, Va. |
| 24. FUNERAL DIRECTOR
Murphy F.H. - Falls Church 1102 W. Broad St. | | 25a. DATE REC'D. BY REGISTRAR
AUG 30 1979 | 25b. REGISTRAR'S SIGNATURE
[Signature] |

TO HOSPITAL OR ATTENDING PHYSICIAN: The [] returned by the hospital or attending physician.



CROWER NOTIFIED 8/13-9 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

9 20725

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|---|---|--|-----------------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) LOIS Ann SHELL HENS DILL | | | 2a. DATE OF DEATH
MONTH 08 DAY 13 YEAR 79 | | 2b. HOUR
8:20A.M. | | |
| 3 SEX
Female | | 4 RACE
Caucasian | | 5 DATE OF BIRTH
MONTH 10 DAY 10 YEAR 40 | | 6 AGE (IN YEARS LAST BIRTHDAY)
38 YRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Prince Georges MD. | |
| 10 CITY OR TOWN OF DEATH
Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Southern Maryland Hospital Center | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Bookkeeper | |
| 12b KIND OF BUSINESS OR INDUSTRY
PAR GAS | | 13a INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13b STREET ADDRESS
217 Acadia Road | | | |
| 14 FATHER'S NAME
FIRST Lee MIDDLE V. LAST Shell | | 15 MOTHER'S MAIDEN NAME
FIRST Clyde MIDDLE V. LAST Moore | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b SOCIAL SECURITY NO.
224-54-9361 | |
| 17 INFORMANT
Lillian Miles same as 13 | | 18 ADDRESS
217 Acadia Road | | 19 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1629
DUE TO, OR AS A CONSEQUENCE OF pulmonary arrest
(b) metastatic lung cancer
DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (10) | | | | | | | |
| 20a DATE OF OPERATION | | 20b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20c AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20d IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR 10 A.M. MONTH 08 DAY 13 YEAR 79 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET Acadia Road CITY OR TOWN Clinton COUNTY Prince Georges STATE MD. | | | |
| 22a I certify that (1) this hospital attended the deceased from Aug 12 19 79 to Aug 13 19 79 and that in my opinion death occurred on the date and hour and from the causes stated above. (2) I did/did not view the body after death. | | | | | | | |
| 22b SIGNATURE
D. J. Naidak | | 22c DEGREE
MD | | 22d ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22e DATE SIGNED
8/13/79 | |
| 22f PHYSICIAN'S NAME (TYPE OR PRINT)
D. J. Naidak | | 22g ADDRESS
Blacost Rd Hyattsville | | 23a BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b DATE
8-17-79 | |
| 23c NAME OF CEMETERY OR CREMATORY
Lee Memorial Garden | | 23d LOCATION
CITY OR TOWN Woodway, Lee COUNTY Virginia STATE MD. | | 24 FUNERAL DIRECTOR
NAME Heath Funeral Home ADDRESS Waldorf, Maryland | | 25a DATE REC'D. BY REGISTRAR
AUG 16 1979 | |
| 25b REGISTRAR'S SIGNATURE
Patricia McCreedy | | | | | | | |

MEDICAL CERTIFICATION

1810



1810



551 Medical Examiner notified
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 7/77
(VR A 15 (4))

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in person.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|---|--|--|---|---|----------------------------|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 7 9 20 / 26
REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
MORRIS L. HEWITT | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
08 30 79
2b. HOUR
2:35 PM | | | | | |
| 3 SEX
Male | | 4 RACE
Caucasian | | 5 DATE OF BIRTH MONTH DAY YEAR
March 11 1905 | | 6 AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGE'S COUNTY MD. | | | | |
| 10 CITY OR TOWN OF DEATH
CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PRINCE GEORGE'S GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sales | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Deale | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Harry Hewitt | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Pearl Morriss | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
578-05-0495 | | 17 INFORMANT ADDRESS
Thelma B. Hewitt - same as 13 | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>acute Myocardial Infarction</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pulmonary Edema</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary failure</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 8/29 19 79 to 8/30 19 79, that (1) (we) last saw the deceased alive on 8/30 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
BARRY ROSENBERG M.D. | | DEGREE
M.D. | | 22c. ADDRESS
6501 LANDOVER RD. CHEVERLY, MD. | | 22d. DATE SIGNED | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
9/1/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland P.G. Maryland | | | | |
| 24. FUNERAL DIRECTOR
NAME
Ranoch F. Home Savings Mcl | | 25a. DATE REC'D. BY REGISTRAR
SEP 10 1979 | | 25b. REGISTRAR'S SIGNATURE
Barry Rosenberg | | | | | | |

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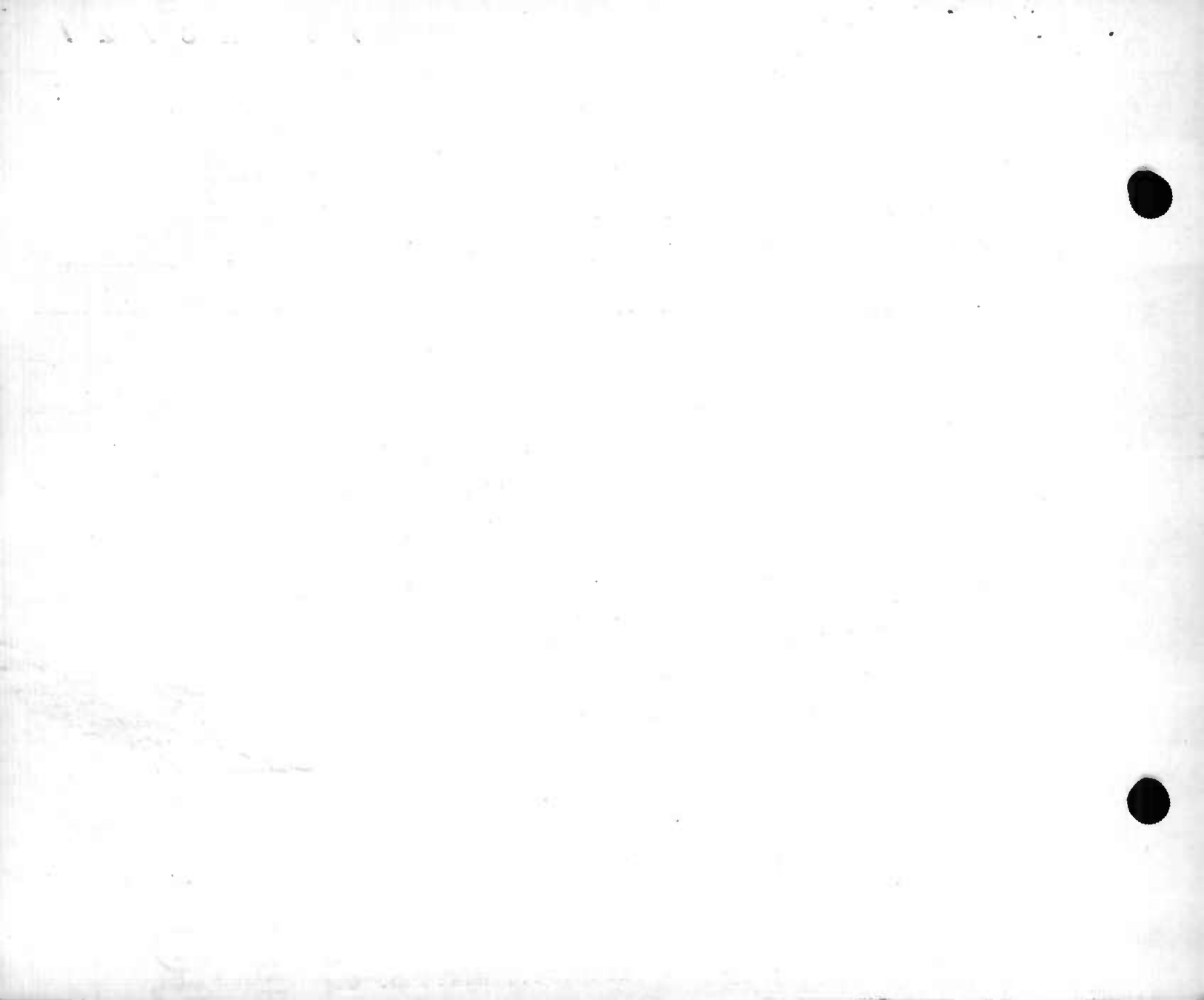
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as above.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|--|--|--|--|--|---|---|---|--|
| FOR STATE REGISTRAR | | | | | REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FRANKLIN A. HIGGS | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
08-28-79 | | | 2b. HOUR
4:30AM | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb 15 11 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Florida | | 9. CITIZEN OF WHAT COUNTRY?
USA | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGES MD. | | | | |
| 12. CITY OR TOWN OF DEATH
CHEVERLY | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PRINCE GEORGES GENERAL HOSPITAL | | | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 15. KIND OF BUSINESS OR INDUSTRY
None | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
16a. STATE
Washington | | | | | 16b. COUNTY
D. C. | | 16c. CITY OR TOWN
D. C. | | 16d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 17. FATHER'S NAME
FIRST MIDDLE LAST
Alfred Higgs | | | | | 18. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BLANCHE SAUNDERS | | | | | |
| 19a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | | | 19b. SOCIAL SECURITY NO.
578-12-5197 | | 17. INFORMANT
Audrey M. Higgs/wife/same as 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Possible Aspiration</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Cerebrovascular Accident</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Cerebrovascular Disease</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>hrs</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>Generalized atherosclerosis; Possible Embolus</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, GARAGE, PARK, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>8/24</u> 19 <u>79</u> to <u>8/28</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>8/27</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 23. SIGNATURE
<u>Donald M. Pachuta</u> | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 24. DATE SIGNED
8/28/79 | | |
| 25. PHYSICIAN'S NAME (TYPE OR PRINT)
DONALD M. PACHUTA | | | | | 26. ADDRESS
2209 Fox Hunt Lane
LUTHERVILLE MD 21093 | | | | | |
| 27a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 27b. DATE
9-1-79 | | 27c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | 27d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood, Md. | | 27e. DATE RECEIVED BY REGISTRAR
SEP 5 1979 | | |
| 28. FUNERAL DIRECTOR
John T. Rhines Co., 3015 12th St., N.E., D. C. | | | | | 29. REGISTRAR'S SIGNATURE
<u>Hurley McBrady</u> | | | | | |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 7 9 20 / 28
REG. NO. | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a DATE OF DEATH MONTH DAY YEAR | | 2b HOUR | |
| JOSEPH | | T. | | HILL | | | | 08 24 79 | | 3:00 PM | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7 UNDER 1 YEAR | | 7 UNDER 24 HRS | |
| MALE | | BLACK | | 3-4-1897 | | 82 | | MONTHS DAYS | | HOURS MIN | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| GEORGIA | | USA | | | | PRINCE GEORGE'S COUNTY MD. | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| CHEVERLY | | PRINCE GEORGE'S GENERAL HOSPITAL | | | | | | RETIRED | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET ADDRESS | | | |
| COTTAGE | | CITY P.G. | | Maryland | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 4142 BUNKER HILL RD | | | |
| 14 FATHER'S NAME | | | | 15 MOTHER'S MAIDEN NAME | | | | ADDRESS | | | |
| UNKNOWN | | | | UNKNOWN | | | | Wash. D.C. | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b SOCIAL SECURITY NO. | | | | 17 INFORMANT | | | |
| YES | | | | 577 10 7257 | | | | Louis Watties 3725 18th St. N.E. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) Congestive heart failure | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Chronic obstructive pulmonary disease | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| Cerebral ischemia | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY | | 21c HOW INJURY OCCURRED | | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | | | | | |
| 21d INJURY OCCURRED | | 21e PLACE OF INJURY | | 21f LOCATION | | | | | | | |
| AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| | | | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 7/13 19 79, to 8/24 19 79, that (I) (we) last saw the deceased alive on 8/24 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED | | | | | |
| T. S. JURY | | MD | | | | 8/24-79 | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS | | | | | | | | | |
| | | 64 90 Landover Road | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION | | 23e COUNTY STATE | | | |
| BURIAL | | 8/30/79 | | FT. LINCOLN | | BLADENSBURG, MARYLAND | | | | | |
| 24 FUNERAL DIRECTOR | | 24a DATE REC'D. BY REGISTRAR | | 24b REGISTRAR'S SIGNATURE | | | | | | | |
| NAME ADDRESS | | SEP 7 1979 | | History/Barney | | | | | | | |
| JOHNSON & JENKINS INC 716 KENNEDY ST, N.W. | | | | | | | | | | | |

MEDICAL CERTIFICATION

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JOHNSON & JOHNSON AND THE KENNEDY ST. 11. 8/30/79 FT. LINCOLN BURIAL

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

872 7932

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 7 9 20729 | | | | | |
|--|--|------------------------------|---|--|--------------------------|--------------------------------------|------|--|--|--|-----------------------------------|---------------------|------|----------|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. | | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR | |
| Mary Agnes Hill | | | | | | | | | 8/19/79 | | | | | 9:05 AM | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | |
| Female | | Caucasian | | August 21 1902 | | 76 | | MONTHS | | DAYS | | HOURS | | MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | |
| Maryland | | U.S.A. | | | | Prince George's MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Clinton | | | Clinton Community Hospital | | | | | | Housekeeper | | Domestic | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| 13a. STATE | | | | | | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | | |
| Maryland | | | | | | | | | | Pr. George's | | Clinton | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | |
| Frank | | | | | John | | | | | Fannie Spalding | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | |
| No | | | | | 217-30-6662A | | | | | Catherine Abell 9606 Gwynndale Dr. Clinton, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Heart attack</u>
DUE TO, OR AS A CONSEQUENCE OF <u>Lower respiratory infection</u>
(b) <u>Uncontrolled diabetes</u>
DUE TO, OR AS A CONSEQUENCE OF <u>I.C.I.A.</u>
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/19</u> , 19 <u>79</u> , to <u>8/19</u> , 19 <u>79</u> , that (I) (we) lost
saw the deceased alive on <u>8/19/79</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) did not see the body after death. | | | | 22b. SIGNATURE
<u>M. Moasser MD</u> DEGREE | | | | 22c. DATE SIGNED
<u>8/19/79</u> | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | | | | | |
| M. MOASSER MD | | | | 8910 WOODYARD RD. CLINTON MD. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | | | 8/22/79 | | Cedar Hill Cemetery | | | | Suitland Pr. George Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| George P. Kalas Funeral Home | | | | AUG 23 1979 | | | | <u>Kalass</u> | | | | | | | |
| KALAS 6160 OXON HILL RD. OXON HILL, MD. | | | | | | | | | | | | | | | |

45021

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 20730 | |
|---|--|--|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Cecil B. HINES | | | | | | | | | | 2a. DATE KNOWN OF DEATH 8-17 1979 | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH Aug 20, 1905 | | 6. AGE (IN YEARS) 73 | | 7c. DATE PRONOUNCED DEAD 8-17 1979 | | 2b. HOUR 11:38 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 83 VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges | | 10. CITY OR TOWN OF DEATH Hyattsville | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Prince Georges Hospital | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter | | 12b. KIND OF BUSINESS OR INDUSTRY Painter | | 13a. STREET ADDRESS 1704 25th Avenue | | 13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 14. FATHER'S NAME George HARRISON HINES | | 15. MOTHER'S MAIDEN NAME Elizabeth Margaret Walker | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes. | | 16b. SOCIAL SECURITY NO. 577-38-9203 | | 17. INFORMANT J.D. Williams | | 17. ADDRESS Annapolis 49 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary and/or cardiovascular disease | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | | | TITLE (SPECIFY) Deputy | | | | DATE SIGNED 8-17-79 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. | | | | ADDRESS 5009 Rayburn Ct., Camp Springs, Md. 20031 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 8/21/79 | | | | 23c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Mem Park | | | |
| 23d. LOCATION CITY OR TOWN Annapolis | | | | COUNTY VA. | | | | STATE | | | |
| 24. FUNERAL DIRECTOR (NAME) Everly Funeral Home | | | | 24b. DATE REC'D. BY REGISTRAR AUG 22 1979 | | | | 25b. REGISTRAR'S SIGNATURE Patricia McCready | | | |

00100



George Harrison
277-38-1001 T.D. Williams, 2224
Harrison, Elizabeth, 11/1/1942
Harrison, George, 11/1/1942

8/21/77
277-38-1001
Harrison, George, 11/1/1942

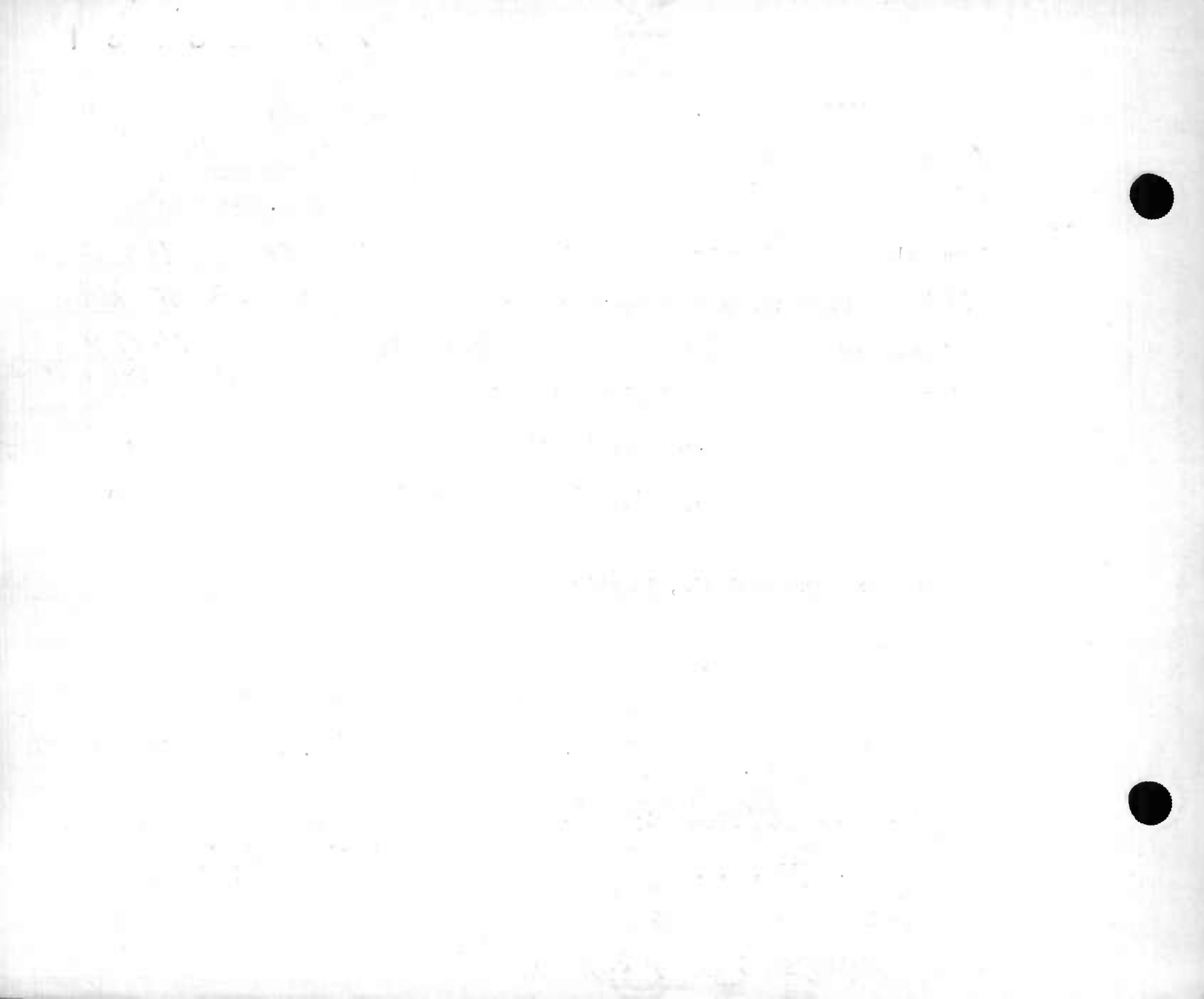
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 7 | 9 | 2 | 0 | 7 | 3 | 1 | | | | | |
|--|--|--|--|---|--|--|--|--|--------------------------------------|---|---|---|-----------------|--|-----------------|----------|--|----------------------------|--|--|--|
| 1- STATE REGISTRAR | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | | | | | |
| | | | William | | | A. | | | HOLLY | | | August 18, 1979 | | | | 1:45 M | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | | | | |
| MALE | | | BLACK | | | 7-1-1908 | | | 71 YRS | | | | MONTHS | | DAYS | | | | | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7c. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | |
| MARYLAND | | | U.S.A. | | | | | | Prince George County MD. | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | | | | | | | | | |
| Glenn Dale | | | Glenn Dale Hospital | | | | | | | | | | | | | | | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| DRIVER | | | | | | | | | | U.S. Gov't | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | | | | | | | |
| D.C. | | | | | | | | | | WASHINGTON | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1614 4th St. N.W. | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | | | |
| WILLIAM HURRY | | | | | | | | | | ELIZABETH HOLLY | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | | | |
| NO | | | | | | | | | | 577-50-8803 | | WILLIAM GIBSON 3722 CAMDON ST SE, WASH. D.C. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Renal Failure | | | | | | | | | | Days | | | | | | | | | | | |
| 1991 | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Undifferentiated Adenocarcinoma with widespread Metastases | | | | | | | | | | Months | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | |
| Pulmonary tuberculosis, inactive | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | | | | | | | | | |
| | | | | P.M. 19 | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| 22. I certify that (X) (this hospital) attended the deceased from Aug. 8, 1979, to Aug. 18, 1979, that (X) (we) last saw the deceased alive on Aug. 18, 1979, and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE | | | | 22c. DATE SIGNED | | | | | | | |
| James W. Wills, M.D. | | | | | | | | | | | | | | August 18, 1979 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | |
| James W. Wills, M.D. | | | | | | | | | | Glenn Dale Hospital
Glenn Dale, Maryland 20769 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| BURIAL | | | | AUG. 24, 1979 | | MC. OLIVET CEM. | | | | WASHINGTON, D.C. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | | | | | 24b. ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| W.W. CHAMBERS CO. | | | | | | | | | | 517 11th St SE, WASH. D.C. | | | | AUG 27 1979 | | | | | | | |

BP _____



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79

20732

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JOSEPH SIDNEY HURLBURT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
8 26 79 | | 2b. HOUR
4:02 AM |
| 3 SEX
MALE | 4 RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR
11 08 08 | | 6 AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Mass. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGES MD. | |
| 10 CITY OR TOWN OF DEATH
CLINTON | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SOUTHERN MARYLAND | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED Chief | | 12b. KIND OF BUSINESS OR INDUSTRY
Navy |
| 13a. STATE
MARYLAND | | 13b. COUNTY
P.G. | 13c. CITY OR TOWN
INDIAN HEAD | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Arthur Hurlburt | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Coleman | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
1925-1945 | | 17 INFORMANT
ADDRESS
SO. MD. HOSP. SURRATTS RD CLINTON MD | |

| | | | | | |
|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute purulent meningitis
4660
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(b) Acute bronchitis, bronchopneumonia
(c) left lung. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Senility. | | | | | |
| 19a. DATE OF OPERATION
8-24-79 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Senility. | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from 8-24-79 to 8-26-79 , that I (we) lost saw the deceased alive on 8-26-79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Mridula Singh | | DEGREE
M.D. | | 22c. DATE SIGNED
Aug. 27, 79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MRIDULA SINGH | | 22e. ADDRESS
Southern Maryland Hosp. Clinton Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
8-31-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Park Hill Cem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Marbury, Charles, Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
HUNT FUNERAL HOME, WALDORF, MD. | | ADDRESS
SEP 4 1979 | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
[Signature] | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



JOSEPH RICHARD BURLEIGH

MALE CAUCASIAN 22 08 70

CLINTON SOUTHERN BAYLARD

WYOMING 1900

WYOMING 1900

WYOMING 1900

WYOMING 1900

WYOMING 1900

WYOMING 1900

WYOMING 1900

WYOMING 1900

WYOMING 1900

WYOMING 1900

WYOMING 1900

WYOMING 1900

WYOMING 1900

WYOMING 1900

WYOMING 1900

Hunt-Freeze Home Insurance Co.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial or cremation.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|--|--------------------------------------|--|-------------------------|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| DECEASED NAME (TYPE OR PRINT) | | DATE | | HOUR | |
| William G Idol | | Aug 10 79 | | 10:15 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Female | White | 4 20 18 | 61 | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| North Carolina | U.S.A. | | Prince Georges MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Clinton | Southern Md. Hosp. Center | Seamstress | | Sewing | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
| Maryland | | Charles | Waldorf | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 318 Lake Drive |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | ADDRESS | |
| Thomas Bailey | | Georgia James | | Lanham, Maryland | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | | |
| No | | 237-07-0386 | Linda Houser 9899 Goodluck Road | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiomyopathy</u> (b) <u>as a consequence of</u> (c) <u>Cancer of Artery</u> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION | |
| WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost | | | | | |
| saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | |
| above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| Rene Grace | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 10 Aug 79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| Rene Grace MD | | Clinton MD 20735 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION |
| Burial | | 8/14/79 | Gilford Mem. Cem. | | Greensboro Gilford N.C. |
| 24. FUNERAL DIRECTOR'S NAME (TYPE OR PRINT) ADDRESS | | | | | |
| Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd. Clinton, Md. | | | | | |
| 25. DATE REC'D. BY REGISTRAR | | 26. REGISTRAR'S SIGNATURE | | | |
| AUG 21 1979 | | | | | |

BP

Prince Georges

x

North Carolina

Clinton

Lawrence

Charles

Lawrence

Lawrence

Thomas

Henry

Lawrence

No

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20734
REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | |
|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Loy Ernest JEFFRIES | | 2a. DATE KNOWN OF DEATH
ESTIMATED 8-4-79 | | 2b. HOUR
1030 |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 23, 1899 | 6. AGE (IN YEARS)
LAST BIRTHDAY
80 | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN
1030 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash. D.C. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince Georges MD. | |
| 10. CITY OR TOWN OF DEATH
Cheverly | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Prince Georges Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
U. S. Govt. Ret. | 12b. KIND OF BUSINESS OR INDUSTRY
Dept Agricult. | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY CITY OR TOWN
Maryland Prince Georges Md Rainier | | 13b. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13c. STREET ADDRESS
4212 Russell Avenue Apt 1 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Jeffries | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Daler | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
579-46-0149 | | |
| 17. INFORMANT
ADDRESS
P2401 Ellen Court | | Virginia Bittenbender Silver Spring, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary atherosclerotic cardiac vascular disease
4292
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE
Augusto P. Rodeiguez | | TITLE (SPECIFY)
M.D. Deputy | | DATE SIGNED
8-4-79 |
| EXAMINER'S NAME
(TYPE OR PRINT)
Augusto P. Rodeiguez | | ADDRESS
5019 Rayburn Court, Camp Springs Md 20731 | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
Aug 8, 79 | 23c. NAME OF CEMETERY OR CREMATORY
Prospect Hill | 23d. LOCATION
CITY OR TOWN
Washington, D.C. | |
| 24. FUNERAL DIRECTOR
Hines/Rinaldi Funeral Home | | 25a. DATE REC'D. BY REGISTRAR
AUG 8 1979 | | 25b. REGISTRAR'S SIGNATURE
Anthony McCurdy |
| 11800 New Hampshire Ave. Silver Spring, Md. | | | | |

THE UNIVERSITY OF CHICAGO
LIBRARY



[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 7 9 2 0 7 3 5 | |
|--|--|--|--|---|--|---|--|--|----------------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
EDITH A. JOHNSON | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
AUGUST 17, 1979 | | 2b. HOUR
9:35p M | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
SEPT. 12, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
0 0 | | 7. IF UNDER 24 HRS
HOURS MIN.
0 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
MASSACHUSETTS | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGE'S MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
GREENBELT | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(TYPE OF INSTITUTION)
GREENBELT CONVALESCENT HOME | | | | 12a. USUAL OCCUPATION
(TYPE OF OCCUPATION OR WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
OWN HOME | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Montgomery | | 13c. CITY OR TOWN
Silver Spring | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
10105 Deven Court | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John McGowan | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Hutchinson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | 16b. SOCIAL SECURITY NO.
141 42 0109 | | 17. INFORMANT ADDRESS
Robert Johnson Same as #13 (Son) | | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
4292 DUE TO, OR AS A CONSEQUENCE OF ASCVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: "year"
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
Senility | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immediate | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/25 19 73 , to 8/17 19 79 , that (I) (we) last saw the deceased alive on 8/5 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
D. Granite MD | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
8/17/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
D. Granite MD | | | | 22e. ADDRESS
115 Centerway Greenbelt MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
Burial | | 23b. DATE
Aug/23/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Hillside Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Monson Hampden Mass. | | 25a. DATE RECEIVED BY REGISTRAR
AUG 21 1979 | | | |
| 24. FUNERAL DIRECTOR
Francis Gasch's Sons Funeral Home, P.A.
Hyattsville, Maryland | | | | | | 25b. REGISTRAR'S SIGNATURE
Henry McBrady | | | | | |

BP

28162

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

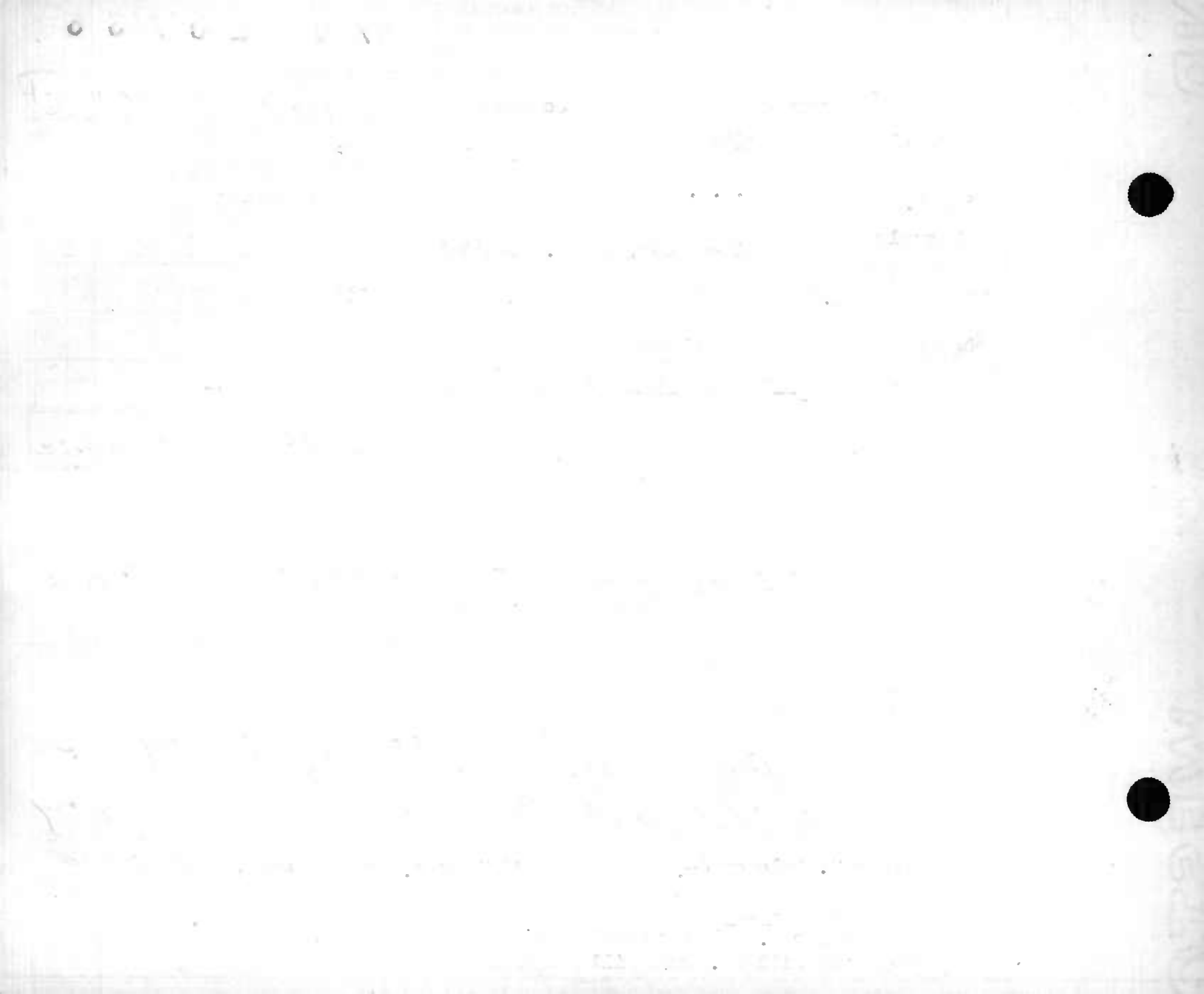
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M
(VRA 15, 4) 7/78

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

| | | | |
|---|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
Gertrude M Johnson | | 2a. DATE OF DEATH MONTH DAY YEAR HOUR
AUG. 9 1979 10:05 P.M. | |
| 3 SEX
Female | 4 RACE
White | 5 DATE OF BIRTH MONTH DAY YEAR
10 19 1921 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASH D.C. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 6. AGE (IN YEARS LAST BIRTHDAY)
59 YRS.
IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 10 CITY OR TOWN OF DEATH
Cheverly | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Prince Georges Gen. Hospital | 9 BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGES MD. | |
| 12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY P.G. | | 12b. KIND OF BUSINESS OR INDUSTRY
BOARD OF EDUCATION | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
HOWARD ROGERS | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MARTHA WILKINS | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
577-22-0062 | |
| 17 INFORMANT ADDRESS
CHARLES JOHNSON JR same as 13a | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 2396 BRAIN TUMOR
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 MONTHS | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
CEREBRAL THROMBOSIS C. W. W. | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jun 6 19 58 to Aug 9 19 79, that (I) saw the deceased alive on Aug 9 19 79, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Thomas G. Maloney Jr. | | 22c. DATE SIGNED
10 Aug 79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Thomas G. Maloney Jr. | | 22e. ADDRESS
4814 71st. Ave Landover, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
8-13-79 | |
| 23c. NAME OF CEMETERY OR CREMATORY
FT LINCOLN | | 23d. LOCATION CITY OR TOWN COUNTY STATE
BRENTWOOD P.G. MD | |
| 24 FUNERAL DIRECTOR NAME
George P. Kalas | | 25a. DATE REC'D. BY REGISTRAR
AUG 14 1979 | |
| 24 ADDRESS
6160 Oxon Hill Rd. Oxon Hill Maryland | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 9 20737 | | | |
|--|--|--|--|--|--|--|--|
| 1 - FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
AGNES E. JONES | | | | 2a. DATE OF DEATH MONTH DAY YEAR
08-29-79 | | 2b. HOUR
11:45 AM | |
| 3. SEX
F | | 4 RACE
N | | 5. DATE OF BIRTH MONTH DAY YEAR
3-20-1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
66 | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGE'S MD. | |
| 10. CITY OR TOWN OF DEATH
CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PRINCE GEORGE'S GENERAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY
None | |
| 13a. STATE
M | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
Scent Muesant | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
William T. Jones | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Jane Brown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
None | | 17. INFORMANT ADDRESS
William H. Jones 8800 Burnside Dr. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1749
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension
DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
79 8780 79 | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 79, to 8780 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) see the body after death. | | | | | | | |
| 22b. SIGNATURE
Lewis H. Dennis | | | | DEGREE
M.D. | | 22c. DATE SIGNED
8/29/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LEWIS H. DENNIS, M.D. | | | | 22e. ADDRESS
831 UNIV. BLVD. SILVER SPRING, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE
9-1-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Harmony | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Highland Park MD | |
| 24. FUNERAL DIRECTOR NAME
112 Washington Sons | | | | 24b. ADDRESS
Nannie H. Burroughs Ave | | 25a. DATE REC'D. BY REGISTRAR
SEP 17 1979 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Rafaela McBrady | | | |

100-100-100-100

Figure 2.2

2591-1932

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

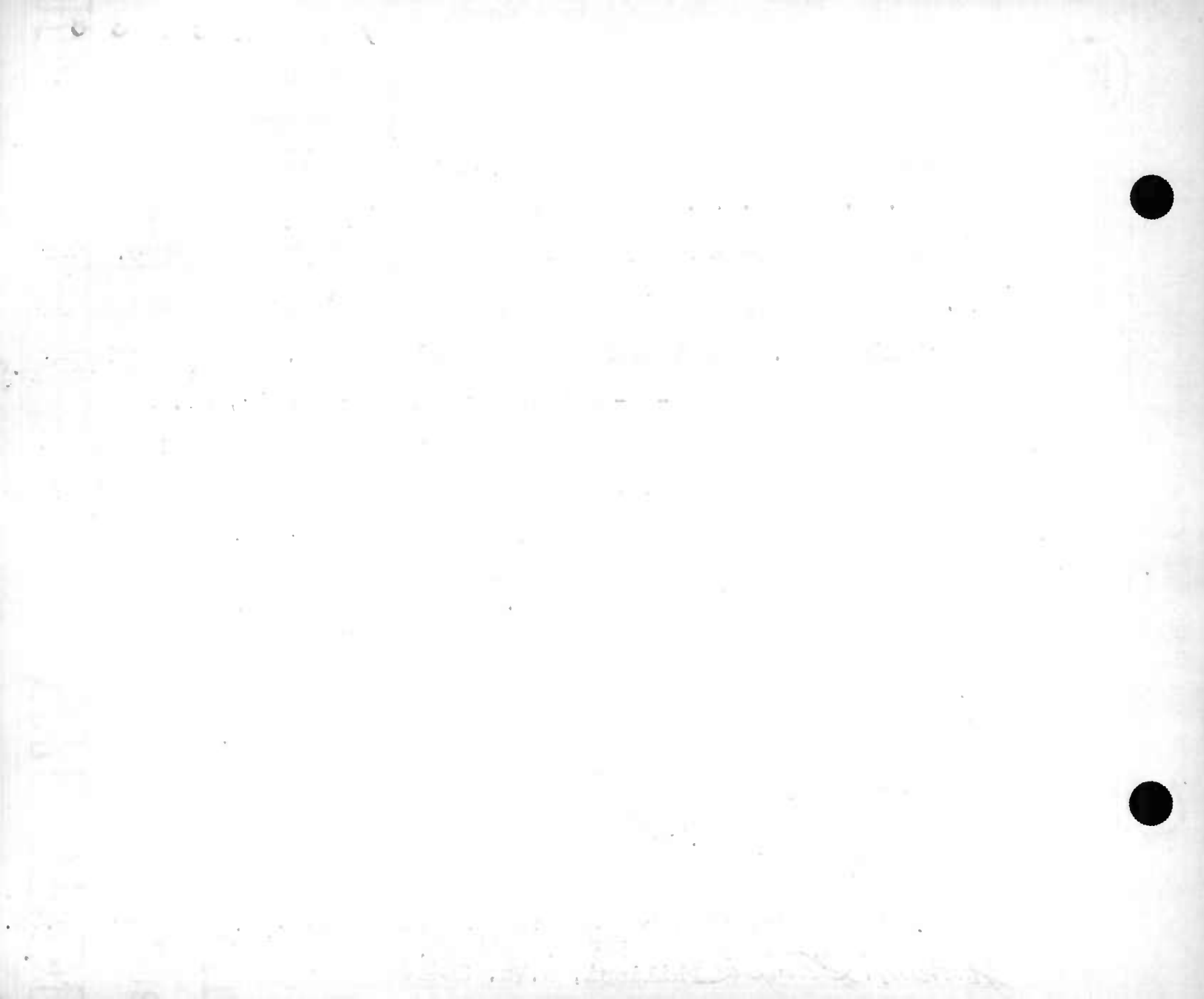
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

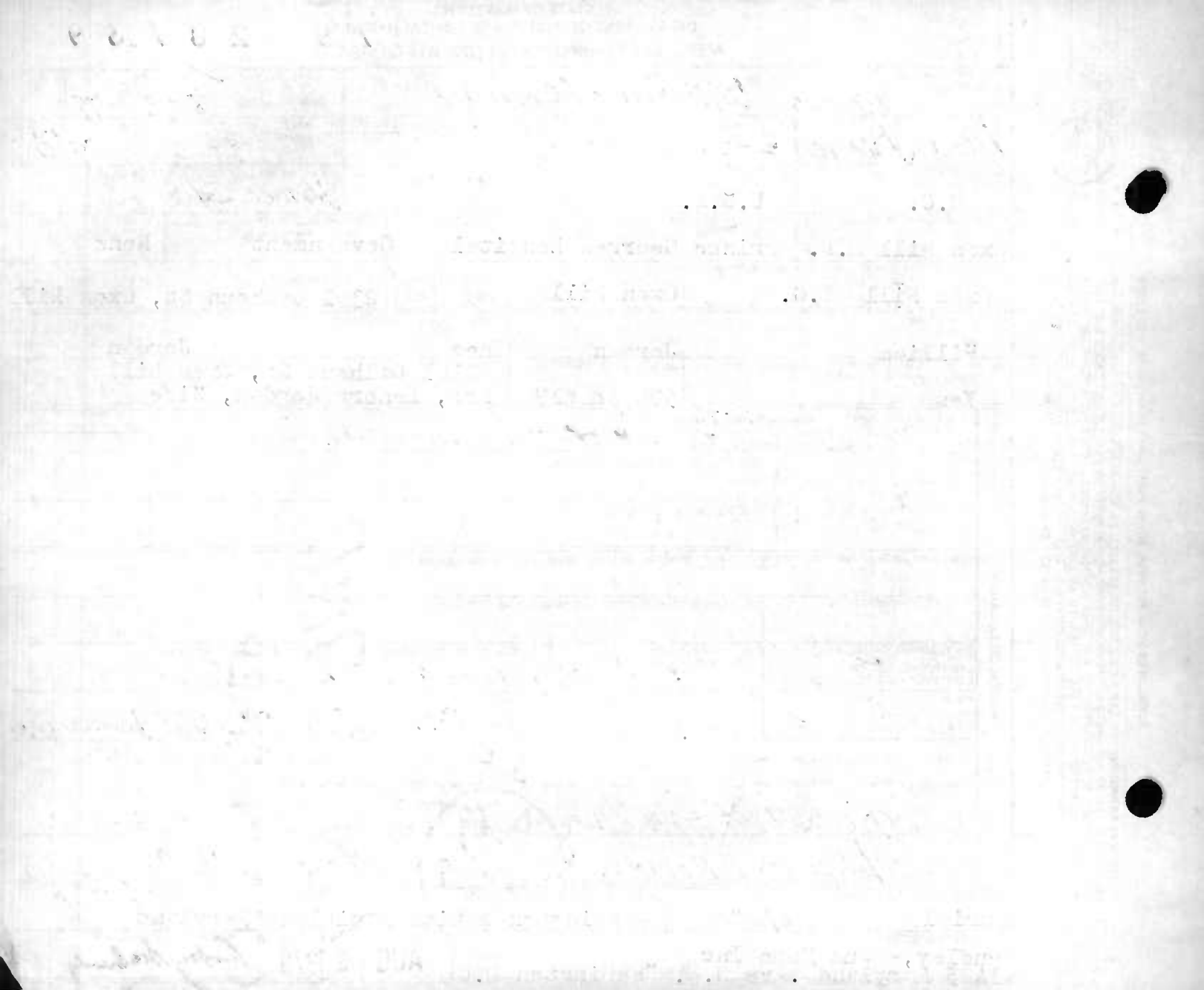
1. FOR
STATE
REGISTRAR

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
SYLVIA MAE JONES | | | 2a. DATE OF DEATH
MONTH DAY YEAR
August 18, 1979 | | 2b. HOUR
5.02 P | | | | | | |
| 3 SEX
Female | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH DAY YEAR
March 29, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | 8. IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
W.Va. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince Georges County MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Lanham | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Doctors Hospital of Pr. Geo. Co. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
Groc. Store | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE
Md. | | | | 13b. COUNTY
Pr George | | 13c. CITY OR TOWN
Bowie | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3704 Irongate Lane | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William A. Everson | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Minnie B. Daugherty | | | | 16. ADDRESS
3704 Irongate Lane | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
235-56-4617 | | 17. INFORMANT
Sue Ann Luther | | | | 17. ADDRESS
Bowie, Md. 20715 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>
<u>410-</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost:
(b) <u>Acute myocardial infarction</u>
(c) <u>Coronary artery disease</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>10 minutes</u>
<u>8 hours</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
<u>Diabetes mellitus</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> 19 <u>79</u> , to <u>Aug 18</u> , 19 <u>79</u> , that (I) <u>was</u> last saw the deceased alive on <u>Aug 18</u> , 19 <u>79</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (If <u>not</u> last saw the body after death.) | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Leonard P. Appel</u> | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
8/19/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LEONARD P. APPEL, MD | | | | | | 22e. ADDRESS
3231 SUPERIOR LA Bowie Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
Aug 22 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Masonic Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Phillippi Barbour W.Va. | | | | |
| 24. FUNERAL DIRECTOR
NAME
<u>John M. Stemple</u> | | | | | | ADDRESS
385 S. Main St.
Phillippi, W.Va. | | 24. DATE REC'D. BY REGISTRAR
2416 AUG 29 1979 | | | |
| | | | | | | | | REGISTRAR'S SIGNATURE
<u>Patricia C. Brady</u> | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 20739
REG. NO. | |
|--|--|--|--|---|--|---|--|---|--|-------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>James William JORDAN</i> | | | | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR <i>8-3 1979</i> | | 2b. HOUR
M <i>12:13</i> | | | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>Black</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR <i>2-24-46</i> | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) <i>33 YRS.</i> | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR <i>8-3 1979</i> | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>D.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Prince Georges</i> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Oxon Hill M.D.</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Prince Georges Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Government</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>None</i> | | | |
| 13a. STATE
<i>Oxon Hill</i> | | 13b. COUNTY
<i>P.G.</i> | | 13c. CITY OR TOWN
<i>Oxon Hill</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<i>2301 Calhoun St, Oxon Hill</i> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>William Jordan</i> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Inez Jordan</i> | | | | 17. INFORMANT
<i>2301 Calhoun St, Oxon Hill</i>
<i>Mrs. Lenora Jordan, Wife</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) <i>Yes</i> | | | | 16b. SOCIAL SECURITY NO.
<i>577 58 8190</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Carbon monoxide intoxication</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 8-3 1979</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
<i>Inhaled car exhaust fumes</i> | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
<i>Car</i> | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<i>2301 Calhoun St, Oxon Hill, Prince Georges</i> | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> M.D. <i>Deputy</i> MEDICAL EXAMINER | | | | DATE SIGNED <i>8-3-79</i> | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez</i> | | | | ADDRESS <i>5009 Rayburn Ct., Camp Springs</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>8/8/79</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Washington National</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Washington D.C.</i> | | | | | |
| 24. BURIAL DIRECTOR
NAME ADDRESS
<i>Dudley S. Fun Home Inc.</i>
<i>1425 Maryland Ave N.E.</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>AUG 9 1979</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Robert M. Brady</i> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | 7 20740 | |
|---|--|---|---|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
STEVE KARAVASILIS | | | 2a. DATE OF DEATH
08-05-79 | | | 2b. HOUR
12:30AM | |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH 12 DAY 27 YEAR 1925 | 6. AGE (IN YEARS LAST BIRTHDAY)
53 YRS | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGES MD. | | | |
| 10. CITY OR TOWN OF DEATH
CHEVERLY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PRINCE GEORGES GENERAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Helper | | 12b. KIND OF BUSINESS OR INDUSTRY
Trucking - Del. | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. CITY OR TOWN Pr. George's Bowie | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
17511 Queen Anne Bridge Rd. | | |
| 14. FATHER'S NAME
FIRST Phillip MIDDLE LAST Karavasilis | | | 15. MOTHER'S MAIDEN NAME
FIRST Margaret MIDDLE LAST Gray | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
578-34-1426 | | 17. INFORMANT
Marietta Kidwell ADDRESS 17511 Queen Anne Bridge Rd. Bowie, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Renal Insufficiency
1579
DUE TO, OR AS A CONSEQUENCE OF
(b) metastatic pancreatic carcinoma
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
72 hours
1 year | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION
10 July 1979 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
4 Aug 1979 | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR 19
P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10 July 1979 to 5 Aug 1979 , that (I) (we) lost the deceased alive on 4 Aug 1979 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) review the body after death. | | | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
Thomas A. Bensinger | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
5 Aug 79 | |
| 22d. ADDRESS
831 Univ Blvd E. S. 1 Spg Md 20903 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
8/8/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN Suitland COUNTY Pr. George STATE Maryland | |
| 24. FUNERAL DIRECTOR'S NAME
George P. Kalas Funeral Home
6160 Oxon Hill Rd., Oxon Hill, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 8 1979 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 20741 | | | |
|---|--|----------------------|--|---|--|---|--|--|--|---|--|--|--|--|--|--|--|--|--|-------------------|--|-------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>John Steele</i> FIRST <i>KELLEY</i> MIDDLE <i>Jr.</i> LAST | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <i>8-2</i> DAY <i>19</i> YEAR <i>79</i> | | | | | | | | | | 2b. HOUR <i>M</i> | | | |
| 3. SEX <i>Male</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH <i>2-9</i> DAY <i>59</i> YEAR <i>25</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>25</i> YRS. | | IF UNDER 1 YR. MONTHS <i></i> DAYS <i></i> | | IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i> | | 2c. DATE PRONOUNCED DEAD <i>8-2</i> MONTH <i>19</i> YEAR <i>79</i> | | | | | | | | | | 2d. HOUR <i>M</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i> | | | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> MD. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Cheverly</i> | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince George's Gen'l Hosp</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Welder</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Shop</i> | | | | | | | | | | | |
| 13a. STATE <i>Md.</i> | | | | 13b. COUNTY <i>Pr. Geo's</i> | | 13c. CITY OR TOWN <i>Lanham</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>6306 Barrs Lane</i> | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST <i>John</i> MIDDLE <i>S.</i> LAST <i>Kelley Sr</i> | | | | | | 15. MOTHER'S MAIDEN NAME FIRST <i>Dolores</i> MIDDLE <i></i> LAST <i>Ruggieri</i> | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>yes</i> | | | | 16b. SOCIAL SECURITY NO. <i>219-48-7703</i> | | 17. INFORMANT ADDRESS <i>John S. Kelley Sr. Father, Lanham, Md.</i> | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
<i>9554</i> IMMEDIATE CAUSE (a) <i>Gunshot wound to precordial region</i>
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) <i></i>
(c) <i></i> | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 8-2 1979</i> | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Shot self</i> | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Bath room</i> | | | | 21f. LOCATION STREET <i>Hecht Co.</i> CITY OR TOWN <i>P. George</i> COUNTY <i>Pr. George</i> STATE <i>Md</i> | | | | | | | | | | | | | | | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> | | | | TITLE (SPECIFY) <i>M.D.</i> | | | | MEDICAL EXAMINER | | | | DATE SIGNED <i>8-3-79</i> | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez</i> | | | | ADDRESS <i>5609 Rayburn Ct., Camp Springs Md</i> | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | | | 23b. DATE <i>8/7/79</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i> | | | | 23d. LOCATION CITY OR TOWN <i>Brentwood</i> COUNTY <i>Pr. Geo's</i> STATE <i>Md.</i> | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR <i>Francis Gasch's Sons, PA</i> | | | | ADDRESS <i>Hyattsville, Md.</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>AUG 6 1979</i> | | | | 25b. REGISTRAR'S SIGNATURE <i>Robert M. Bailey</i> | | | | | | | | | | | |

1470



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9

20742

REG. NO.

1 - FOR
STATE
REGISTRAR

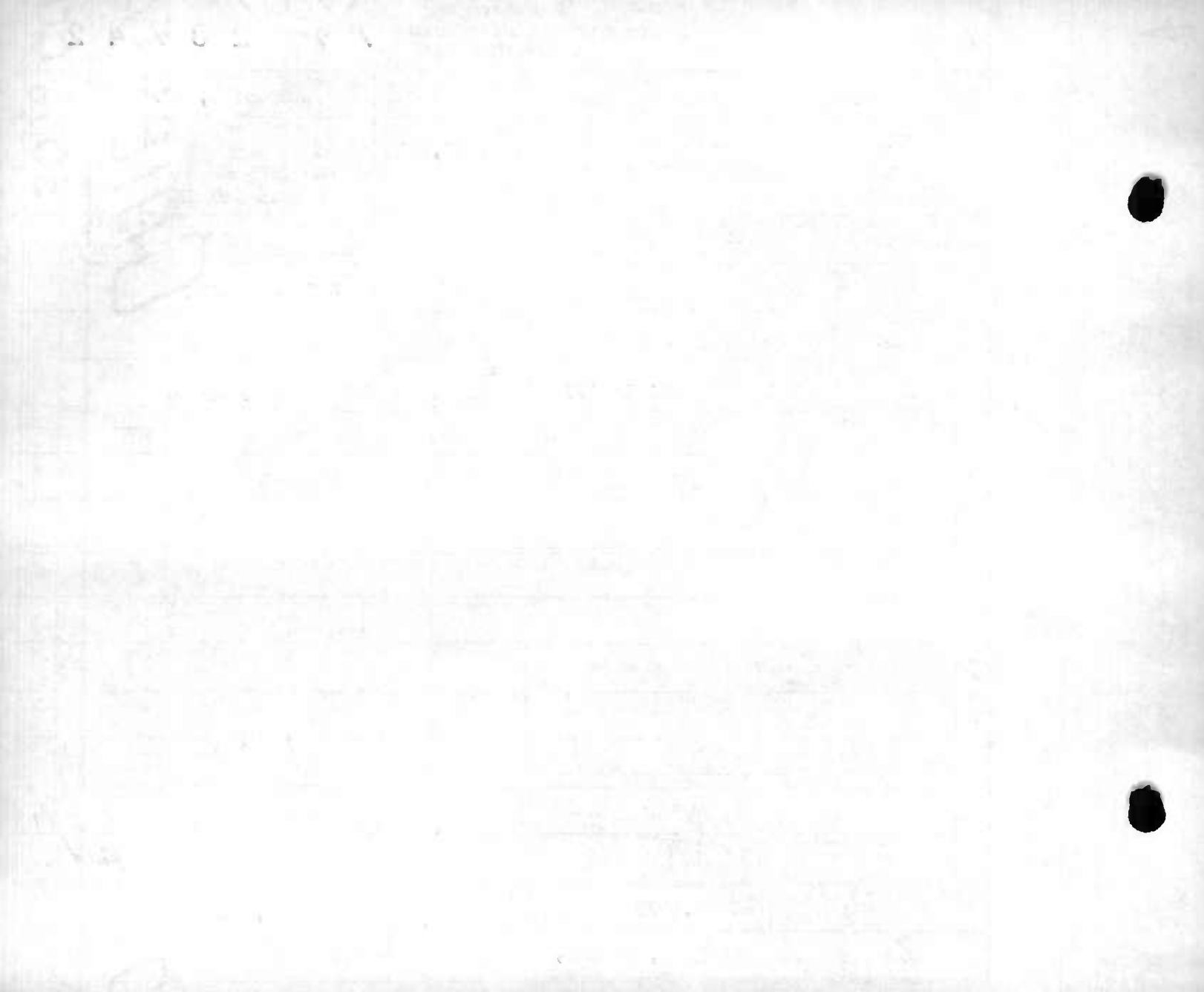
| | | | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|--|-----------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) RICHARD REID KING | | | 2a. DATE OF DEATH
MONTH DAY YEAR
AUGUST 2, 1979 | | | 2b. HOUR
9PM | | | | | |
| 3 SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
JANUARY 17, 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
NEW JERSEY | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGE | | | | | |
| 10. CITY OR TOWN OF DEATH
LAUREL | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
402 DOMER AVENUE | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
ELECTRICIAN | | 12b. KIND OF BUSINESS OR INDUSTRY
US GOVT | | | |
| 13a. STATE
MD | | | 13b. COUNTY
PG | | 13c. CITY OR TOWN
LAUREL | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
402 DOMER AVENUE | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
STEPHEN KING | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ISABELLA BARCLAY | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW 2 | | 17. INFORMANT
ADDRESS
MARY ALICE KING SAME AS ABOVE | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Dehydration from Metastatic disease
1489
DUE TO, OR AS A CONSEQUENCE OF
(b) Epidermoid Carcinoma of Hypopharynx
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that we (this hospital) attended the deceased from 1-6-1979 to 7-23-1979 , that we lost
saw the deceased alive on 7-23-1979 , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above, we (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
B.G. Manepols, MD | | | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
8-3-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
B.G. Manepols, MD | | | | | | 22e. ADDRESS
314 Second St. Laurel, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
AUG 6, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
MD NATIONAL MEM. PARK | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
LAUREL, MARYLAND | | | |
| 24. FUNERAL DIRECTOR
NAME
DONALDSON FUNERAL HOME, LAUREL, MARYLAND | | | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 15 1979 | | 25b. REGISTRAR'S SIGNATURE
Anthony McCreedy | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene. Page 3 should be filed within 22 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Augustus
Louis A. Kirtland | | 2a. DATE OF DEATH
MONTH DAY YEAR
August 19, 1979 | | 2b. HOUR
2:03aM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
November 30, 1891 | |
| 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
7 20 | | 8. IF UNDER 72 HRS
HOURS MIN.
2 03 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ohio | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince Georges MD. | | 10. CITY OR TOWN OF DEATH
Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Southern Maryland Hospital Center | |
| 12a. USUAL OCCUPATION
(PAPE OF WORK FOR MOST OF WORKING LIFE)
Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY
Auto | | 13a. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13a. STREET ADDRESS
Rt. #1 Box 316 | | 13b. CITY OR TOWN
Charles | | 13c. COUNTY
Waldorf | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Kirtland | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Martha Fawcett | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | |
| 16b. SOCIAL SECURITY NO.
578-10-0056 | | 17. INFORMANT
ADDRESS
Alice B. Kirtland same as 13 | | 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EDEMA
4140
DUE TO, OR AS A CONSEQUENCE OF
(b) CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF
(c) ARTERIOSCLEROTIC HEART DISEASE | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
CHRONIC OBSTRUCTIVE PULMONARY DISEASE - CARCINOMA OF COLON | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 WKS | | 1 DAY | |
| 19a. DATE OF OPERATION
8/10 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
CHRONIC OBSTRUCTIVE PULMONARY DISEASE - CARCINOMA OF COLON | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
8/10 1979 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
8/10 1979 | | 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
8/10 1979 | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
8/10 1979 | | 22a. I certify that (I) (this hospital) attended the deceased from 8/10 1979 to 8/18 1979 , that (I) (we) last saw the deceased alive on 8/15/79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
Dr. Bruno Kolega | |
| 22c. DATE SIGNED
8/19/79 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BRUNO KOLEGA MD, FOC, Dr. HOUSEL | | 22e. ADDRESS
4400 STAMP RD. TRAPPE HILLS, MD 20631 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
8-19-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Metropolitan Crem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alexandria, Virginia | | 24. FUNERAL DIRECTOR
NAME ADDRESS
Hunt Funeral Home Waldorf, Maryland | | 25a. DATE RECEIVED BY REGISTRAR
8/20/79 | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | 25c. REGISTRAR'S NAME
[Name] | | 25d. REGISTRAR'S ADDRESS
[Address] | |

BP

346.12712 .A a2v31

1

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

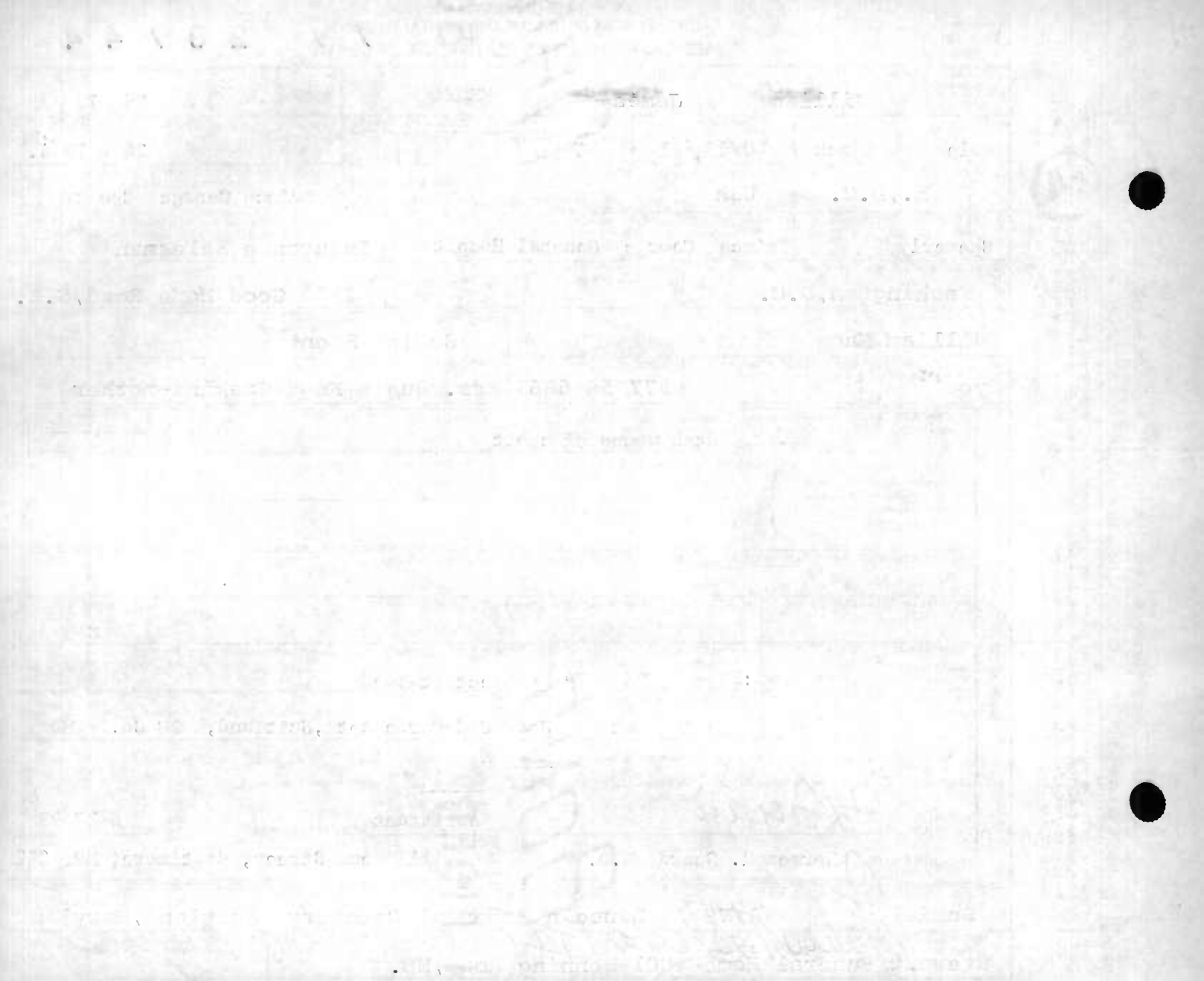
BP

DMMH - 17
(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20744
REG. NO.

| | | | |
|---|---|---|--|
| 1- FOR STATE REGISTRAR | | 20744 | |
| 1 DECEASED NAME
(TYPE OR PRINT) | | 2a DATE KNOWN OF DEATH | |
| FIRST MIDDLE LAST
William James KNOX | | ESTIMATED MONTH DAY YEAR HOUR
8 26 19 79 a.m. | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (IN YEARS) |
| male | black | 10/11/41 | 37 YRS. |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b CITIZEN OF WHAT COUNTRY? | 8 MARRIED | 9 BALTIMORE CITY OR COUNTY OF DEATH |
| Wash., D.C. | USA | NEVER MARRIED | Prince George County MD. |
| 10 CITY OR TOWN OF DEATH | 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b KIND OF BUSINESS OR INDUSTRY |
| Cheverly | Prince George General Hospital | Insurance Salesman | |
| 13a STATE | 13b CITY OR TOWN | 13c STREET ADDRESS | |
| Washington, D.C. | | 2300 Good Hope Road, S.E. | |
| 14 FATHER'S NAME | 15 MOTHER'S MAIDEN NAME | | |
| FIRST MIDDLE LAST
William Knox | FIRST MIDDLE LAST
Susie Brent | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | 16b SOCIAL SECURITY NO. | 17 INFORMANT | ADDRESS |
| yes | 577 54 6863 | Mrs. Susie Knox Gaskins-mother | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Stab wound of chest</u>
966-
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | |
| 19a DATE OF OPERATION | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? | |
| | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR
5:30xx 8/26 1979 | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
subject stabbed | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
Parking Lot | 21f LOCATION CITY OR TOWN COUNTY STATE
ShadySideGardenApts, Suitland, PG Co., MD | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>H. S. Guard</u> | | TITLE (SPECIFY) Assistant MEDICAL EXAMINER | |
| EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D. | | DATE SIGNED 8/27/79 | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b DATE 9/1/79 | |
| 23c NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery | | 23d LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland | |
| 24 FUNERAL DIRECTOR NAME John F. Stewart | | 25a DATE REC'D BY REGISTRAR AUG 31 1979 | |
| Stewart Funeral Home-4001 Benning Road, NE. | | 25b REGISTRAR'S SIGNATURE | |



Medical Examiner notified 8/24/79

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79 20745

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT) John | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Aug. 24, 1979 | | | 2b. HOUR
4:50 PM | | | |
| 3 SEX
Male | | 4 RACE
Caucasian | | 5 DATE OF BIRTH
MONTH DAY YEAR
Dec. 29 1906 | | 6 AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | | 7 IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Prince Georges Cty. MD. | | | |
| 10 CITY OR TOWN OF DEATH
Cheverly | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Prince Georges General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Supervisor | | 12b. KIND OF BUSINESS OR INDUSTRY
L. C. B. | |
| 13a. STATE
Maryland | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
Bowie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
3540 Northshire Lane | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
John - Kovacs | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Julia - Soho | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES) N/A | | 17 INFORMANT
ADDRESS
Margaret Kovacs Same as #13e | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) CARDIAC ARREST | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
20 MIN. | |
| 4140
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) CORONARY ARTERY DISEASE | | | | | | | | 10 YEARS | |
| (c) GENERALIZED ARTERIOSCLEROSIS | | | | | | | | 15 YEARS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 7-14- 19 76 to 8-24- 19 79 , that (I) (we) lost saw the deceased alive on 8-22- 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
John Cosma M.D. | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
8/24/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John Cosma, M.D. | | | | | | 22e. ADDRESS
6776 Racetrack Rd. Bowie, Maryland 20715 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
27 Aug. 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Lakemont Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Davidsonville, Maryland | | |
| 24 FUNERAL DIRECTOR
NAME
Robert G. Beall | | | | | | ADDRESS
9013 Annapolis Rd. | | 25 REGULAR'S SIGNATURE
Robert G. Beall | |

BALTIMORE, MARYLAND 21201

AUG 28 1979

2010



2010

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 20746
REG. NO. | | |
|--|-------------------------|---|--|---|---|--|-----------------------|---|--|---|--|-----------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) William Hayes LAURIE | | | | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED 8-5-79 | | 2b. HOUR
11 |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
7-23-05 | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS.
14 | IF UNDER 1 YR.
MONTHS DAYS
14 | IF UNDER 24 HRS.
HOURS MIN.
14 | 2c. DATE PRONOUNCED DEAD
8-5-79 | 2d. HOUR
11 | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash. D. C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince Georges MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Cheverly | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Prince George's Gen'l Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Warehouseman | | 12b. KIND OF BUSINESS OR INDUSTRY
Dept. Store | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Pr. Geo's | | 13c. CITY OR TOWN
Bladensburg | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5999 Emerson Street Apt 105 | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James C. Laurie Sr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Eva G. Hayes | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
no | | | | 16b. SOCIAL SECURITY NO.
578-10-6212 | | 17. INFORMANT
ADDRESS 8761 Riverdale Rd
Pearl L. Gormley (sister) New Carrollton, Md | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary atherosclerotic Coroided Vaso calt disease
4292
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Padriano | | | | M.D. July | | | | MEDICAL EXAMINER
DATE SIGNED 8-5-79 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Padriano | | | | ADDRESS 5007 Rayburn Ct., Camp Springs | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
8/9/1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Congressional Cem | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington D. C. | | |
| 24. FUNERAL DIRECTOR
NAME
Francis Gasch's Sons, PA Hyattsville, Md. | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 10 1979 | | 25b. REGISTRAR'S SIGNATURE
P. K. ... | | |



17-10-1912



FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

P.G. MEDICAL EXAMINER
NOTIFIED

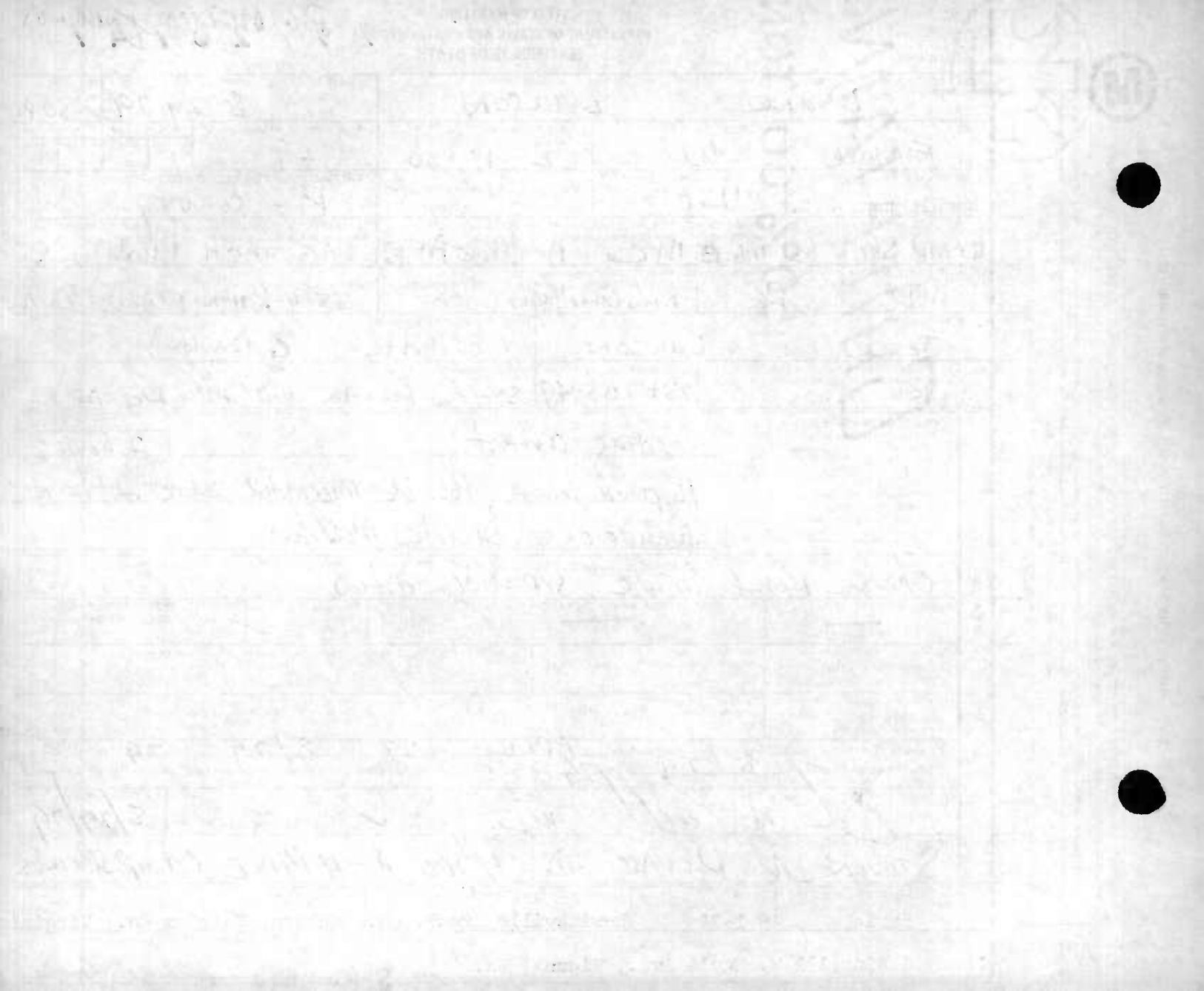
REG. NO.

| | | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|---------------------|-----------|---------------------------------------|---------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
DIANE | | MIDDLE
LAWSON | | LAST
LAWSON | | 2a. DATE OF DEATH | | MONTH
8 | DAY
29 | YEAR
79 | 2b. HOUR
2:30 PM | |
| 3. SEX
Female | | 4. RACE
W | | 5. DATE OF BIRTH | | MONTH
2 | | DAY
14 | | YEAR
50 | | 6. AGE (IN YEARS LAST BIRTHDAY)
29 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
P.G. COUNTY MD. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
RAMP SPRING | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
MG MC Andrews AFB | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
LAB. TECH | | 12b. KIND OF BUSINESS OR INDUSTRY
Hospital | | | | | | | | |
| 13a. STATE
MD | | 13b. COUNTY
PG | | 13c. CITY OR TOWN
New Carrollton | | 13d. INSIDE CITY LIMITS?
<input type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET ADDRESS
5514 KAREN-ELAINE DRIVE | | | | | | |
| 14. FATHER'S NAME
Jesse | | MIDDLE
LAWSON | | LAST
LAWSON | | 15. MOTHER'S MAIDEN NAME
Charlotte | | MIDDLE
G. (LAWSON) | | LAST
G. (LAWSON) | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
UNK | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO.
231-705849 | | 17. INFORMANT
STEVEN POLLAK M.D. (Office Records) | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
2500
DUE TO, OR AS A CONSEQUENCE OF
(b) Hyperkalemia Possible Myocardial Infarct 2+ hours
DUE TO, OR AS A CONSEQUENCE OF
(c) Juvenile onset Diabetes Mellitus
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hours | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
Chronic Renal Failure, S/P Pericarditis | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from APRIL 19 79 to 8/29 19 79, that (I) (we) last saw the deceased alive on 8/29 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.) | | | | | | | | | | | | | | |
| 22b. SIGNATURE
S. M. Pollak | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
8/29/79 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
STEVEN M POLLAK MD | | 22e. ADDRESS
4700 AUTH PLACE, CAMP SPRINGS. | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
9-1-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Lewinsville Presb. Ch. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
McLean, Fairfax Co., Virginia | | 25a. DATE REC'D. BY REGISTRAR
SEP 5 1979 | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Money & King, 171 W. Maple Ave., Vienna, Va. | | 25b. REGISTRAR'S SIGNATURE
L. H. H. H. | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|--|
| FOR
1 - STATE
REGISTRAR | | | | | REG. NO. 9 20748 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MARY MIDDLE Elizabeth LAST LEATHERWOOD | | | | | 2a. DATE OF DEATH MONTH 08 DAY 30 YEAR 79 2b. HOUR 0:30 AM | | | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH April 1, DAY 1901 YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY)
78 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U S A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGE'S COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PRINCE GEORGE'S GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE Md 13c. COUNTY Pro Georges 13d. CITY OR TOWN Hyattsville | | | | | 13e. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13f. STREET ADDRESS
5911 37th avenue | | |
| 14. FATHER'S NAME
FIRST Edward MIDDLE Lucas LAST | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Mary MIDDLE Swann LAST | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO.
579 10 8226 | | 17. INFORMANT ADDRESS
John H Leatherwood W. Hyattsville, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RECENT ACUTE MYOCARDIAL INFARCTION
5789
DUE TO, OR AS A CONSEQUENCE OF
(b) Pressure of hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Pulmonary + renal failure + coagulopathy | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Pressure of hemorrhage | | 19c. AUTOPSY
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-24 19 79 to 8-30 19 79, that (I) (we) lost the deceased alive on 8/30/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Jerome Sandler | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
8/31/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JEROME SANDLER, M.D. | | | | 22e. ADDRESS
6490 LANDOVER RD. LANDOVER, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
9/4/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN BRENTWOOD COUNTY Pro Georges STATE Md. | | | |
| 24. FUNERAL DIRECTOR
NAME F. Gasch's Sons P A Hyattsville, Md. ADDRESS | | | | 25a. DATE RECEIVED BY REGISTRAR 8-31-79 25b. REGISTRAR'S SIGNATURE | | | | | |

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• **Interests:**

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 9 20749
REG. NO. | | | | |
| 1 DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Calvin Thomas Lee | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
August 6, 1979 | | | 2b. HOUR
2:45 p.m. | |
| 3 SEX
Male | | 4 RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 3 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN
IF UNDER 24 HRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince George's MD. | | | |
| 10 CITY OR TOWN OF DEATH
Riverdale | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Eugene Leland Memorial Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Ford Motor Co. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
D.C. | | 13b. COUNTY | | 13c. CITY OR TOWN
Wash. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1112 M St. N.W. | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Fredrick Lee | | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie Mirah | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
577-362-326 | | 17 INFORMANT ADDRESS
Grace C. Lee III @ m St. N.W. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinomatosis</u>
<u>1629</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Carcinoma of right lung</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>One month</u>
<u>Six months</u> | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>November 17</u> , 19 <u>74</u> , to <u>August 6</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>August 6</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Carl J. Houmann</u> | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
8-6-1979 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Carl J. Houmann | | | | | 22e. ADDRESS
4404 Queensbury Road, Riverdale, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
8-10-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Nat. Harmony Cem. | | 23d. LOCATION
CITY OR TOWN
Sandover, Md. | | STATE | |
| 24 FUNERAL DIRECTOR
NAME
Frazier 389 R.I. Ave N.W. Wash. D.C. | | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 16 1979 | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE
<u>Henry McCready</u> | | | | |

MEDICAL CERTIFICATION

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Medical Examiner notified by office of Mendro
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

9 20750

REG. NO.

| | | | | | |
|---|--|--|---|--|--|
| 1 - FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | 1:14P M | |
| Harry P Lett | | Aug 09 1979 | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR | |
| Male | White | January 20, 1905 | 74 | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | USA | | Prince George County MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Laurel | Greater Laurel Beltsville Hospital | foreman | State Roads Comm. | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
| MD | Howard | Laurel | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 9237 Scaggsville Road | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| James P. Lett | | Martha Everly | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| no | | 220 36 9876 | June Bays above | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 410- IMMEDIATE CAUSE (a) <u>Cardiovascular collapse.</u> | | | | | 1-5 hr |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction</u> | | | | | 10-15 hr |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic heart disease</u> | | | | | Yrs. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 1</u> 19 <u>77</u> , to <u>August 9</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>August 9</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | | | 22c. DATE SIGNED | |
| <u>Gursewa S. Pabla MD</u> | | | | <u>Aug 9 1979</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | |
| <u>GURSEWA S. PABLA, MD</u> | | | | <u>704 GORMAN AVE, Suit 4, LAUREL, Md - 20810</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Burial | | Aug 12, 1979 | Mt Zion Cemetery | | Flintsburg, Carroll Co. Md |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| <u>Donaldson JH</u> | | AUG 15 1979 | | <u>Johny McBrady</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|--|--|---|---|--|------------------------------|--|---|----------------------|
| 1. FOR
STATE
REGISTRAR | | | | | 7 9 20751
REG. NO. | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Marsha Liebman | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
August 10, 1979 | | | | | 2b. HOUR
11:10 am |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 25 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince George's MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Riverdale | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Eugene Leland Memorial Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
City Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
N.Y.C. | | |
| 13a. STATE
Fla. | | | | | 13b. COUNTY
unknown | | 13c. CITY OR TOWN
Margate | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Louis Glazer | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Dora Liebman | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
unknown | | 17. INFORMANT
ADDRESS
Flushing, N.Y.
Sheila Watler, 71-60 163rd St. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Metastatic Histiocytic Lymphoma</i>
2000 DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from <i>7/12</i> 19 <i>79</i> to <i>8/10</i> 19 <i>79</i> , that (we) lost saw the deceased alive on <i>8/10</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Byrl Johnson</i> | | | | DEGREE
MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<i>8/10/79</i> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John Melnick, M. D. | | | | 22e. ADDRESS
4404 Queensbury Road, Riverdale, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
8/12/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Beth Moses | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Pinelawn, Suffolk, N.Y. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Danzansky-Goldberg Mem. Ch., Rockville, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 16 1979 | | 25b. REGISTRAR'S SIGNATURE
<i>Henry McCready</i> | | | | |

125055

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 9 20752 | |
|---|--|---|--|--|---|--|--|---|--|---------|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Geraldine L. Linthicum | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
August 10 1979 | | | 2b. HOUR
9:30A M | | | |
| 3 SEX
Female | | 4 RACE
Cauc. | | 5 DATE OF BIRTH MONTH DAY YEAR
Jan 6 1910 | | 6 AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Va. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Prince George's MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Lanham | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Doctor's Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS
Maryland Pr. Geo. Temple Hills YES <input type="checkbox"/> NO <input type="checkbox"/> 2995 Brinkley Road | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Andrew Hunt | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Fannie Butts | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS
Kenneth R Moore 7903 Colonial Lane Clinton, Md. | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line. (a) and (b) are for PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>
496- DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Chronic obstructive Pulmonary</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pneumonia</i> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-2 19 79, to 8-10 19 79, that (I) (we) last saw the deceased alive on 8-9 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Rafael Lee | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
8-10-79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Rafael Lee | | | | 22e. ADDRESS
Clinton Md 20735 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
8-14-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Suitland Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME
Robert E Wilhelm | | | | Funeral Home
Suitland Maryland | | 25a. DATE REC'D. BY REGISTRAR
AUG 15 1979 | | 25b. REGISTRAR'S SIGNATURE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

9 20753

| | | | | | | | | | |
|---|--|--|---|--|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
John Hubert LYONS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
08 04 79 | | | 2b. HOUR
11:40 PM | | | |
| 3 SEX
Male | | 4 RACE
Caucasian | | 5 DATE OF BIRTH
MONTH DAY YEAR
November 7, 1925 | | 6 AGE (IN YEARS LAST BIRTHDAY)
53 | | 6 IF UNDER 1 YEAR
MONTHS DAYS
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Not available | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGE'S COUNTY MD. | | | |
| 10 CITY OR TOWN OF DEATH
CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PRINCE GEORGE'S GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Iron worker | | 12b. KIND OF BUSINESS OR INDUSTRY
Bridge Const. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE 13b COUNTY 13c CITY OR TOWN
Fla. Palm Beach Lantana | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
602 N. 7th St. | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Not Available | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Not Available | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
WW II 577-22-7152 | | 17. INFORMANT
ADDRESS
709 Lucerne Ave. Richard C. Sorgini, Lake Worth, Fla. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
431- Cerebral Hemorrhage
IMMEDIATE CAUSE (a) _____
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-27-1979 , to 8-4-1979 , that (I) (we) last saw the deceased alive on 8-4-1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
S. R. Oza | | | | | | DEGREE
M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
8/6/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
S. R. Oza | | | | | | 22e. ADDRESS
PGGH. Chevy, MD 20785 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Removal | | | 23b. DATE
8/7/1979 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Lake Worth, Fla. | | |
| 24. FUNERAL DIRECTOR
NAME
Robert A. Pumphrey Funeral Homes, P.A. | | | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 08 1979 | | 25b. REGISTRAR'S SIGNATURE
Betty Pauline | |

BP

U. S. S. S. R.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 7. 9 20 / 54
REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
LACY L. MADDOX | | | | | 7a. DATE OF DEATH
MONTH DAY YEAR
08-23-79 | | | 7b. HOUR
3:12 AM | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug. 3, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
77 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGE'S MD. | | | | |
| 10. CITY OR TOWN OF DEATH
CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PR.GEO./EXTENDED CARE FACILITY | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Manager | | 12b. KIND OF BUSINESS OR INDUSTRY
Peoples Drug | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | 13b. COUNTY
Prince Geo. | | 13c. CITY OR TOWN
Cheverly | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Dabney Fox Maddox | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Julia Lewis | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
577 07 6319 | | 17. INFORMANT
ADDRESS
Jetta Lee Maddox Same as #13 (Wife) | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prostatic Cancer - Metastasis
185-
DUE TO, OR AS A CONSEQUENCE OF (b) Bone + Liver, Small Int.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Coronary Artery Disease
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Bronchitis
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-21-1979 to 8-23-1979 , that (I) (we) last saw the deceased alive on 8-21-1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
J. L. Lacey | | DEGREE | | 22c. DATE SIGNED
8-23-79 | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHANNES-SAHAKIAN MD | | | | 22e. ADDRESS
6001 Landover Rd Cheverly MD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
8/27/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood P.G. Md. | | 23e. DATE REC'D BY REGISTRAR | | |
| 24. FUNERAL DIRECTOR
Francis Gasch's Sons Funeral Home, P.A. | | | | 25. REGISTRAR'S SIGNATURE
AUG 27 1979 | | | | | | |
| 26. HYATTSVILLE, MARYLAND | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. 9 20755 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
CRIST L. MADSEN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR P
08 23 79 5:35 M | | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
August 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS
82 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Italy | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGE'S COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
EXTENDED CARE FACILITY | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Waiter-(ret) | | 12b. KIND OF BUSINESS OR INDUSTRY
Restaurant | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Maryland PG Captiol Hts | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5400 Northfield Road | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Unknown Madsen | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Unknown | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
450 16 5390 | | 17. INFORMANT (friend) ADDRESS
Charles F. Altobelli Dist. Hts. Md. 5801 Marlboro Pi | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CUA
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD C angina
DUE TO, OR AS A CONSEQUENCE OF (c) senility
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
History of Pancreatitis | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-12-1978 to 8-23-1979 , that (I) (we) last saw the deceased alive on 8-23-1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE H. A. Molavi M.D. DEGREE M.D. | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 8.24.79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. A. MOLAVI M.D. | | | | | 22e. ADDRESS 6005 Landover Rd, Chevy, Md | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SP-15)
Cremation | | 23b. DATE
30Aug1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Suitland PG Md | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS
Robert E. Wilhelm Funeral Home Suitland, Md | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 5 1979 | | 25b. REGISTRAR'S SIGNATURE
<i>Notary/Deputy</i> | | |

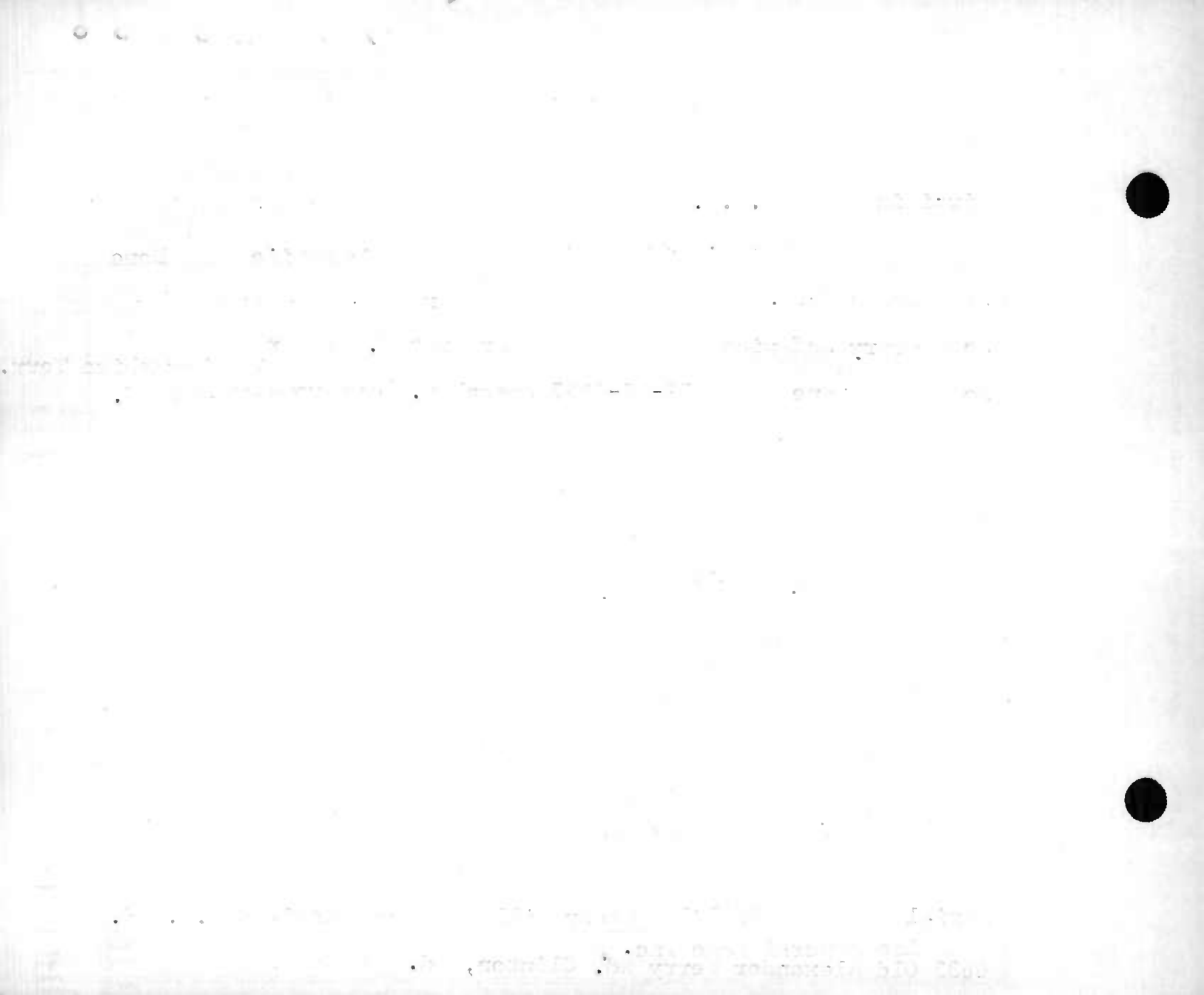
220

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. 9 20756 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
MARTHA L. MARCERON | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
08 13 79 | | | 2b. HOUR
5:10p M | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
03 25 98 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince Georges County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SOUTHERN MARYLAND HOSPITAL CENTER | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
None | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Maryland Prin. Geo. Silver Hill | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
3815 St. Barnabus Rd. 20023 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
John Henry Jeffries | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Margaret F. Redman | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Joseph E. Marceron | | ADDRESS
6204 Yorkshire Terr. Bethesda Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>
586-
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Respiratory Failure</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Renal Failure</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>Myocardial Infarction</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>7/22/79</u> 19 <u>79</u> , to <u>8/13</u> 19 <u>79</u> , that (1) (we) last saw the deceased alive on <u>8/13</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Dr. David R. Leonarduzzi</u> | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
8/14/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. David R. Leonarduzzi | | | | | 22e. ADDRESS
2901 Fairlawn St. Wilkrest Heights Md | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
8/17/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Suitland P.G. Md. | | | |
| 24. FUNERAL DIRECTOR NAME
Lee Funeral Home Inc.
6633 Old Alexander Ferry Rd. Clinton, Md. | | | | | 25a. DATE RECEIVED BY REGISTRAR
AUG 24 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>Robert M. Brady</u> | | |



M

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

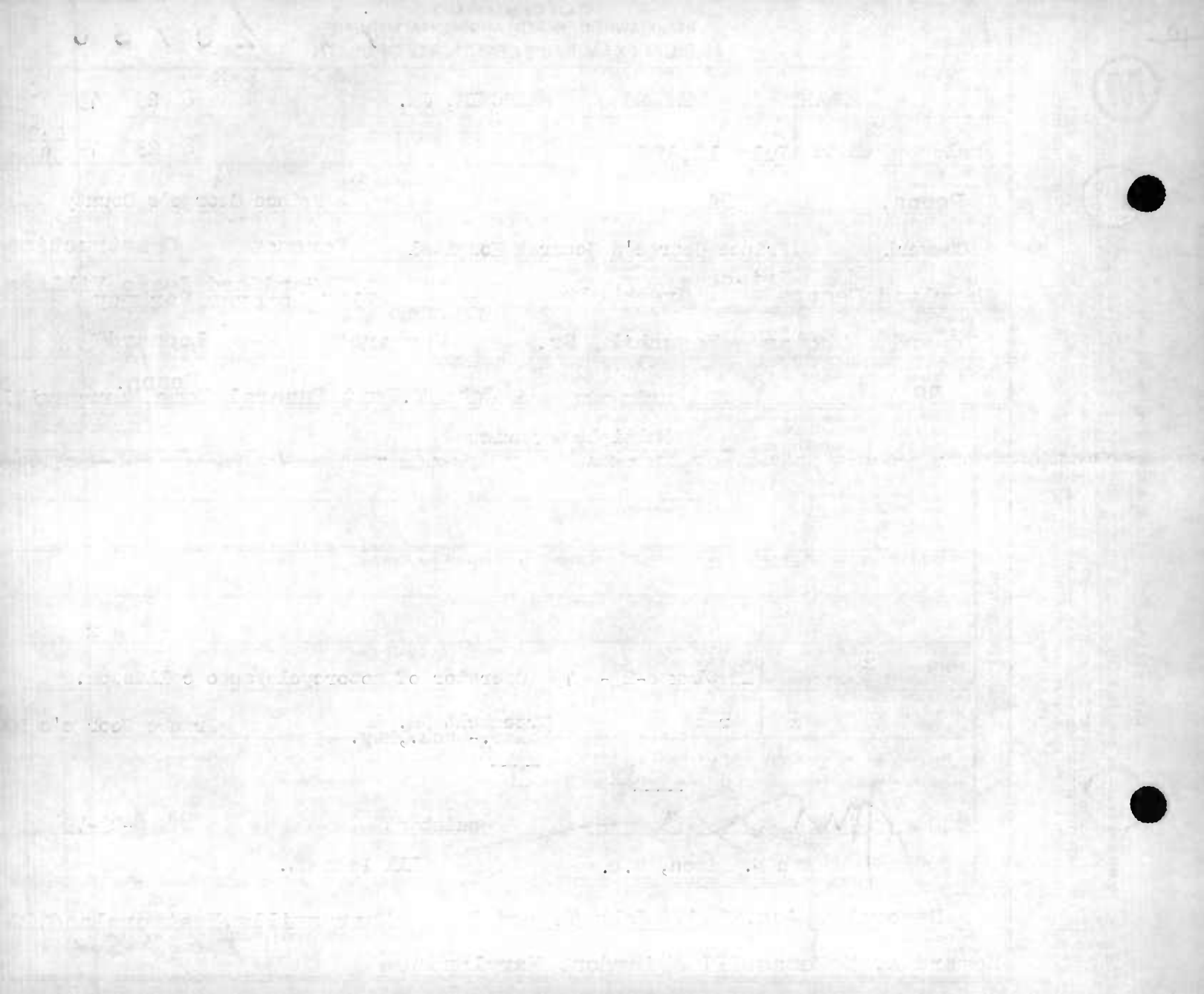
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 7 20757 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| Edwina | | June | | MARRON | | August 23, 1979 | | 224 | | P.M. | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| Female | | Cauc. | | June 26, 1910 | | 69 | | YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Penna. | | U.S.A. | | | | Prince Georges MD. | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Cheverly | | Prince Georges Gen. Hospital | | | | | | Retired | | School Teacher | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| | | | | Maryland | | P.G. | | Bowie | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 13e. STREET ADDRESS | | | | | |
| Forest Glen Lee | | | | Grace Lord | | 4000 Clover Court | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT ADDRESS | | | | | |
| no | | | | 213-38-1675 | | Hugh W. Marron, 4000 Clover Ct., Bowie, Md. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Sudden - deep arrest</u> | | | | | | | | | | | |
| 4275 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>vascular spasm - hypertension - hypothyroidism</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 5, 1979</u> to <u>present</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>July 25, 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | 22c. DATE SIGNED | | | | | |
| <u>R.H. Sandstrom</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | Aug. 24, 1979 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | |
| Roy H. Sandstrom | | 7701 Carroll Ave., Takoma Park, Maryland | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Cremation | | Aug. 24, 1979 | | Metropolitan Crematory | | Alexandria, Virginia | | | | | |
| 24 FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Robert G. Beall Funeral Home | | AUG 29 1979 | | | | <u>Robert G. Beall</u> | | | | | |
| 9013 Annapolis Road, Lanham, Maryland | | | | | | | | | | | |





| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 20758
REG. NO. | |
|--|--|-----------------|--|--|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | | |
| 1 DECEASED NAME
(TYPE OR PRINT)
EDWARD THOMAS MARSCHIK, JR. | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
8 23 1979 | | 2b. HOUR
11:26 a | | | |
| 3 SEX
male | | 4 RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 19, 1957 | | 6 AGE (IN YEARS)
LAST BIRTHDAY
22 YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna. | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Prince George's County MD | |
| 10 CITY OR TOWN OF DEATH
Cheverly | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Prince George's General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Foreman | | 12b. KIND OF BUSINESS OR INDUSTRY
Construction | |
| 13a. STATE
Maryland | | | | | | 13b. COUNTY
Prince George's | | 13c. CITY OR TOWN
Greenbelt | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS
Goddard Space Village
7176 Hanover Parkway | | | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Edward Thomas Marschik, Sr. | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret -- Leonard | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
no | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
unknown | | 17. INFORMANT
ADDRESS
John T. Hart Funeral Home, Murrysville, Penna. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple injuries
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
12:01xx 8-23-19 79 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Operator of motorcycle/auto collision. | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
road | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Greenbelt Rd. & Balto.-Wash. Hwy. Prince George's Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE
Ann M. Dixon, M.D. | | | | TITLE (SPECIFY)
Assistant MEDICAL EXAMINER | | | | DATE SIGNED
8-23-79 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | | | ADDRESS
111 Penn St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | | | 23b. DATE
Aug. 23, '79 | | 23c. NAME OF CEMETERY OR CREMATORY
John T. Hart FH | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Murrysville, Westmoreland, PA | | | |
| 24. FUNERAL DIRECTOR
NAME
Howard K. McComas III | | | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 28 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

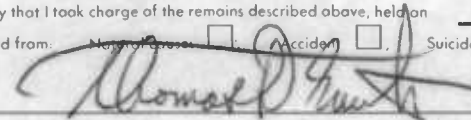
| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|---|---|---|--|--|---|---|---|--|
| 1. FOR STATE REGISTRAR | | 7 9 20759
REG. NO. | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
CLARENCE E MAYHEW | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
08 16 79 | | | 2b. HOUR
8:30AM | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 25 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY)
69 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGES MD. | | | | |
| 10. CITY OR TOWN OF DEATH
CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PRINCE GEORGES GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Landscaper | | 12b. KIND OF BUSINESS OR INDUSTRY
U. S. Gov't | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE D.C. 13b. COUNTY Prince Georges | | | | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
1603 Ritchie Marlboro Rd. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Ernest W. Mayhew | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Clara Padgett | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
-- | | 17. INFORMANT (spouse) ADDRESS
Catherine A. Mayhew Same as #13 | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>
410-
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
48 hr | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>Stroke</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/8</u> 19 <u>79</u> , to <u>8/16</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>8/15</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Kevin W. Houmense</u> | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
8/17/69 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Kevin W. Houmense | | | | | 22e. ADDRESS
984 MALLARD DRIVE | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
Aug 20-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Washington National | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland PG Md | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert E. Wilhelm Funeral Home | | | | | ADDRESS
Suitland, Md | | 25a. DATE REC'D. BY REGISTRAR
AUG 22 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>Henry McCreedy</u> | |

BP

Y. C. Y. U. S. A.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 20760 | |
|---|--|--|---|--|--|---|--------------------------------------|--|---|----------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST
Luevater Lee McBride | | | 7a. DATE OF DEATH
KNOWN ESTIMATED | | | 7b. HOUR | | |
| 3. SEX
Female | | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 18 '60 19 YRS. | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) | | 7c. DATE PRONOUNCED DEAD | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
S. C. | | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince George's County, MD | | | |
| 10. CITY OR TOWN OF DEATH
Cheverly | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Prince George's General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
N/A | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md | | | 13b. COUNTY
P. G. | | | 13c. CITY OR TOWN
Capt. Hts. | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Lenwood Lee | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Vera Calhoun | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
N/A | | |
| 17. INFORMANT
ADDRESS
Vera Lee | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Gunshot Wound of Head (unspecified)</u>
9654
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
(c) _____ | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR <u>10:30</u> P.M. MONTH <u>7</u> DAY <u>28</u> YEAR <u>1979</u> | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject shot | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
house | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
1210 Clouis Ave., Capitol Heights, P.G., Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Negligence <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | TITLE (SPECIFY)
Deputy Chief | | | DATE SIGNED
7/31/79 | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Thomas D. Smith, M.D. | | | ADDRESS
111 Penn Street | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
8-4-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Lincoln Mem. Cem. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland, Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME
Latney, F. Funeral Home | | | ADDRESS
3831 Ga., Ave. N. W. | | | 25a. DATE REC'D. BY REGISTRAR
8-4-79 | | | 25b. REGISTRAR'S SIGNATURE
H. H. H. H. | | |

U. C. 75. 2.

Items #10a-22a Film G535 9/26/79 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20761
 REG. NO.

| | | | | | | | | | | | |
|--|---------|--|--|---|--|---|--|-------------------------------------|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN
OF ESTI-
MATED | | 2b. HOUR | |
| DICK TRACY MC CORMICK | | | | | | | | August 8 22 1979 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH
MONTH DAY YEAR | | 6. AGE (IN YEARS)
LAST BIRTHDAY | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | 2c. DATE
PRONOUNCED
DEAD | |
| male | negro | JUL 15, 1939 | | 40 YRS. | | | | | | August 8 22 1979 | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | 2d. HOUR
P M | |
| N.C. | | USA | | | | Prince George's County | | | | 4:49 P M | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | |
| Cheverly | | Prince George's General Hosp. (DOA) | | CONSTRUCTION WORKER | | CONSTRUCTION | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | |
| D.C. | | | | WASHINGTON | | | | 427 17th STREET S.E. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | | | | | |
| JAMES MCCORMICK | | BLANCH E LEACH | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| NO | | 244 52 7479 | | REOLIA CLARK MCCORMICK | | 427 17th ST. S.E. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Drowning</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR MONTH DAY YEAR
:46 P.M. 8/22/ 1979 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject drowned | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)
construction site | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Kenilworth Ave. Greenbelt, P.G. Co., Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | TITLE (SPECIFY)
Assistant MEDICAL EXAMINER | | | | | | DATE
SIGNED 8-23-79 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS | | | | | | | | | |
| Ann M. Dixon, M.D. | | 111 Penn St. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| BURIAL | | SEP 1, 1979 | | GREEN FUNERAL HOME | | ROBERSON, N.C. | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| ALEXANDER S. POPE | | 2617 PENNSYLVANIA AVE S.E. | | AUG 29 1979 | | History McCreedy | | | | | |

100-1

100-1

JUL 12 1939

DIV

N.C.

D.C.

JAMES WOODBURN

CHARLES E. LEACH

SEP 25 1939

REGINA CLARK WOODBURN and JOHN E. B. B.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10-15-2009 BY 60322 UCBAW/STP

ROBERTSON, N.C.

JOHN W. WOODBURN

SEP 25 1939

DIVISION

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-15-2009 BY 60322 UCBAW/STP

DHMH - 17
(VR A15 ME (5))
15M/7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20762

| | | | | | |
|---|--|---|---|---|------------------------|
| 1. FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2c. DATE ESTIMATED | | 2d. HOUR | |
| FIRST MIDDLE LAST | | MONTH DAY YEAR | | MONTH DAY YEAR | |
| Marion L. McCray | | 8-15 19 79 | | 5:30 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. |
| Female | White | August 9, 1890 | 89 YRS. | MONTHS DAYS HOURS MIN. | MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED | NEVER MARRIED | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Pa. | U.S.A. | WIDOWED | DIVORCED | Pr. Geo. Co. | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Largo | Manor Care Nursing Home, Largo, Md. | Housewife | | Own Home | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Md. | P.G. | Oxon Hill | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 7720 Bock Rd. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | |
| FIRST MIDDLE LAST | | | FIRST MIDDLE LAST | | |
| George N. McDowell | | | Maria J. Cook | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 217-52-7258 | | Philip R. McCray Address Same as No # 13e. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> | | | | | |
| 888- DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) <u>Fractured Right Hip</u> | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| <u>Arteriosclerosis</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| May 25/79 | | Fractured right hip | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| (P.M.) 5-22 19 79 | | Fell in the bedroom. | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| Home | | 7720 Bock Rd, Oxon Hill, Prince Georges, Maryland. | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| Augusto Rodriguez | | Deputy MEDICAL EXAMINER | | 8-16-79 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | |
| Augusto Rodriguez M. D. | | 5009 Bay View Court, Camp Springs, Md 20031 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 8-20-79 | | Arlington Natl. Cem. | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| F. Gasch's Sons F.H. P.A. Hyattsville, Md. | | AUG 20 1979 | | Anthony McCready | |
| 23d. LOCATION CITY OR TOWN | | COUNTY | | STATE | |
| Arlington | | Arlington | | Va. | |

1401



| | | | |
|---------|-----------------|---------------------------------------|--------------|
| 70 8:30 | 8-15 | Henry | London |
| 70 8:30 | August 15 | August 15, 1880 | Female White |
| | W. Dec. 30. | U.S.A. | Mr. |
| | Wm. Lane | Home, Mrs. Mary, Mrs. Mary, Mrs. Mary | Mr. |
| | 7770 Rock Rd. | Green Hill | Mr. |
| | Cook | McGee | George |
| | Address same as | Philip A. McGee | No |
| | No. 130. | 217-1-770 | |

Technical Drawing
 Formed Right Up

Interocular

7770 Rock Rd.
 217-1-770
 Philip A. McGee
 Address same as
 No. 130.
 Cook
 Wm. Lane
 Home, Mrs. Mary, Mrs. Mary, Mrs. Mary
 U.S.A.
 W. Dec. 30.
 August 15, 1880
 Henry
 London
 8-15
 70 8:30

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20763
REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | |
|--|----------------------------|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Flornice E. McDonald | | 2a. DATE KNOWN OF DEATH
ESTIMATED 8-6 19 79 | | 2b. HOUR
M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH 8 DAY 29 YEAR 85 | 6. AGE (IN YEARS)
LAST BIRTHDAY 43 YRS. | 7. IF UNDER 1 YR.
MONTHS 0 DAYS 0 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH
Cheverly | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
Prince Georges Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK)
Dress Maker |
| 13a. STATE
Md. | | 13b. COUNTY
P.G. | 13c. CITY OR TOWN
Bladensburg | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
Frederick G. Harenburg | | 15. MOTHER'S MAIDEN NAME
Ellen ? | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
219-54-9687 | | 17. INFORMANT
Mary A. McDonald |
| | | | | ADDRESS
Same as # 13 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
7070 Septicemia
IMMEDIATE CAUSE (a) Septicemia
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) Pneumonia which
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Old hip fracture and recent left leg fracture | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE
August P. Riquelme | | TITLE (SPECIFY)
Deputy | | DATE SIGNED
8-7-79 |
| EXAMINER'S NAME
(TYPE OR PRINT) August P. Riquelme | | ADDRESS
5009 Rayburn Court, Camp Springs | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | 23b. DATE
8-8-79 | 23c. NAME OF CEMETERY OR CREMATORY
Congressional Cemetery | | 23d. LOCATION
CITY OR TOWN Washington COUNTY D.C. STATE DC |
| 24. FUNERAL DIRECTOR
NAME F. Gasch's Sons, P.A., ADDRESS Hyattsville, Md. | | 25a. DATE REC'D. BY REGISTRAR
AUG 10 1979 | | 25b. REGISTRAR'S SIGNATURE
Henry McCreedy |



[Faint, mostly illegible text and markings across the page, possibly bleed-through from the reverse side.]

20764
REG. NO.

| | | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
WILLIAM | | MIDDLE
J. | | LAST
MC DONOUGH, JR. | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> 8 11 19 79 | | 2b. HOUR
3:33 P | | | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 11, 1952 27 YRS. | | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
27 YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | | 2c. DATE
PRONOUNCED
DEAD 8 11 19 79 | | | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince George's Co. MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Cheverly | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Prince George's Gen. Hospital (DOA) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)
Meat Cutter | | 12b. KIND OF BUSINESS
OR INDUSTRY
Giant Store | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
P.G. Co. | | 13c. CITY OR TOWN
Bowie | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
13805 Jericho Park Rd. | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas J. McDonough | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Agnes Gary | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No. | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212-66-9837 | | 17. INFORMANT
ADDRESS
Agnes E. McDonough same as #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
8147 IMMEDIATE CAUSE (a) Multiple injuries
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR MONTH DAY YEAR
P.M. 8/11/ 79 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)
Subject riding on hood of car fell off and
was run over | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)
road | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Lemon Bridge Rd. Bowie Pr. Geo. Co., Md. | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE
Ann M. Dixon, M.D. | | TITLE (SPECIFY)
Assistant | | M.D. MEDICAL EXAMINER | | | | DATE
SIGNED 8-12-79 | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT) | | ADDRESS
111 Penn St. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
8/15/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Md. National Mem. Park Laurel, P.G. Co., Md. | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| 24. FUNERAL DIRECTOR
FLECK LAUREL FUNERAL HOME, INC.
7601 Sandy Spring Rd. Laurel, Md. 20810 | | | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 14 1979 | | | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER MUST SIGN AND DATE THE BOTTOM OF THIS CERTIFICATE. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR; PAGE 4 TO THE COUNTY CLERK; PAGE 5 TO THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BF

DHMH - 17
(VR A15 ME (5))
15M 7/76

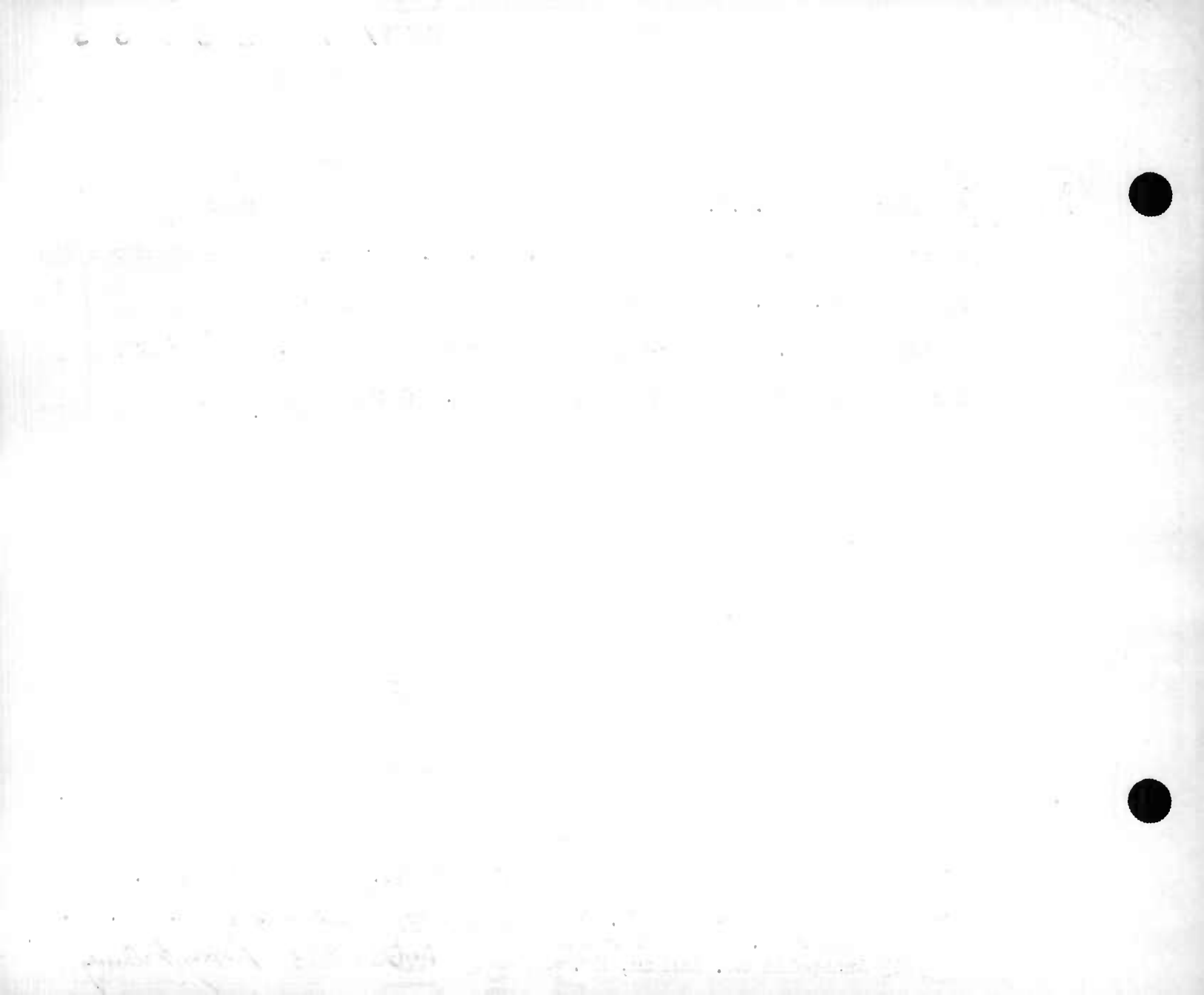


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 7. REG. NO. | | 9 20765 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| James Joseph MCELROY | | | | | | | | August 25, 1979 | | 5:14a.m. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| Male | | Caucasian | | 12 4 1928 | | 50 YRS. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Pennsylvania | | U.S.A. | | | | Prince Georges MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Lanham | | Doctors Hospital Of Pr. Geo. Co. | | Brick Layer - | | Construction | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | |
| Maryland | | Pr. Geo. | | Hyattsville | | | | | | 4833 67th Ave | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | |
| William G. McElroy | | Miriam A. McElroy | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | | | | |
| Yes | | 1947-1948 | | 579-36-4298 Sonia L. McElroy Same as # 13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) 431- INTRA CEREBRAL HEMORRHAGE | | | | | | | | | | 15 DAY | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-10 19 79, to 8-25 19 79, that (I) (we) lost saw the deceased alive on 8-24- 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | | | 22c. DATE SIGNED | | | |
| Roger B. Ingham M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 8-25-79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | |
| Roger Ingham | | 5701 85th Ave. New Carrollton, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 8-28-79 | | Md. Veterans Cemetery | | Cheltenham, Pr. Geo. Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME | | 24b. FUNERAL HOME ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Robert G. Beall | | 9013 Annapolis Rd. Lanham, Md. | | AUG 28 1979 | | History Mabrey | | | | | |

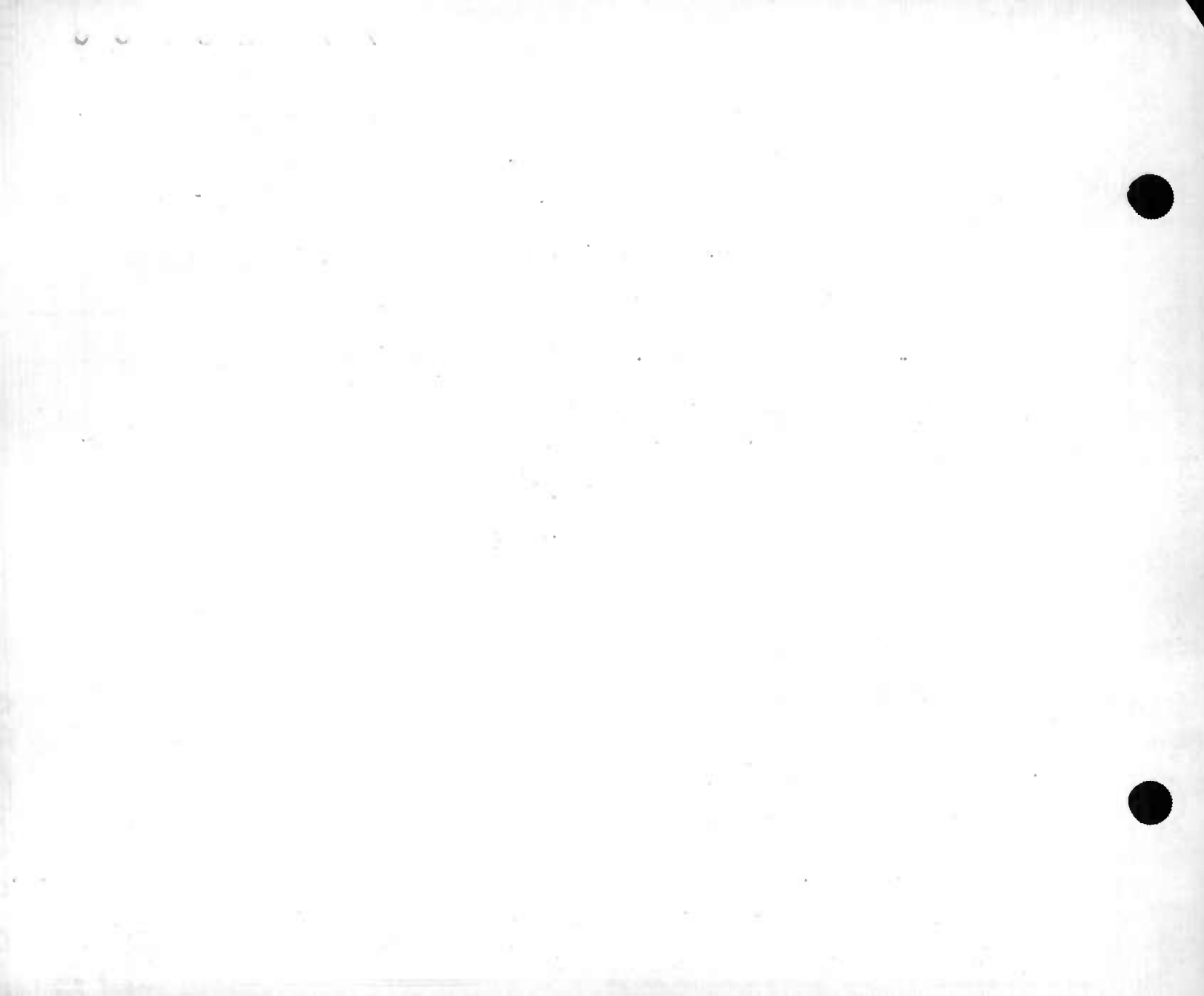


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. | | | | 7 9 20766 | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
ANNA KATHERINE MCGARRY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
AUG. 28 1979 | | | 2b. HOUR
11:40 P.M. | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec 2 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 2a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGE'S COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
LANHAM | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
DOCTORS' HOSP. OF P.G. COUNTY | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
--- | |
| 13a. STATE
Maryland | | | 13b. CITY OR TOWN
Pr. Geo | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
12003 Trim Lane | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Coates | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Katharine Schultz | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | |
| 16b. SOCIAL SECURITY NO.
577 62 1005 | | | 17. INFORMANT
(daughter) Mary C. Knaggs | | | ADDRESS Ocean View, Del.
P.O. Box 186 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Acute Respiratory Arrest</u>
496-
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) <u>Pneumonia</u>
(c) <u>Severe Advanced Chronic Obstructive Pulmonary Disease</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK
NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1962 28 Aug</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>28 Aug</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Benjamin Pecson</u> | | DEGREE | | 22c. DATE SIGNED
8-29-79 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BENJAMIN PECSON | | 22e. ADDRESS
6106 Old Silver Hill, Rd., Wash., D.C. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
31 Aug 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Mount OLIVET | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington D.C. | | | |
| 24. FUNERAL DIRECTOR
NAME
Robert E. Wilhelm | | ADDRESS
Funeral Home Inc | | 25. DATE REC'D. BY REGISTRAR
AUG 31 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>Robert E. Wilhelm</u> | | | |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 20767 | |
|--|---|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| 1 DECEASED NAME (TYPE OR PRINT) McGILL E. MARGERET | | | | 8-21-1979 9 ^{PM} | |
| 3 SEX F | 4 RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 4-2-1906 | 6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS | | IF UNDER 1 YEAR MONTHS DAYS |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna. | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH Pr. Geo. Md. | | |
| 10 CITY OR TOWN OF DEATH Cheverly | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pr. Geo. Gen. Hosp. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. book binder | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. 13b. CITY OR TOWN Laurel | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Edward Hoffman | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Helt | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 579-03-6341 | | |
| 17 INFORMANT ADDRESS Same as Above | | | 17 INFORMANT Joseph E. McGill, Jr. | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septicemia (Son) 5990 | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) Senility | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Chronic U.T.I. & Catheter | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes | | | | | |
| 19a. DATE OF OPERATION - | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-19-78 to 8-21-79 , that (I) (we) last saw the deceased alive on 8/21/79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE S.C. ARYANGAT MD DEGREE | | | | 22c. DATE SIGNED 8/22/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) S.C. ARYANGAT | | | | 22e. ADDRESS 3308 PERRY ST MT. RAINIER, MD | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8-25-79 | | 23c. NAME OF CEMETERY OR CREMATORY Wash. Nat. Cem. | |
| 23d. LOCATION CITY OR TOWN Suitland COUNTY Pr. Geo. STATE Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc. ADDRESS Mt. Rainier, Md. | | | | 25a. DATE REC'D. BY REGISTRAR AUG 27 1979 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Jeffrey McCreedy | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

9 20768

1. FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|---------|-------------------------------|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| FIRST MIDDLE LAST
LOTTIE K. MEARS | | | MONTH DAY YEAR
08-12-79 | | | 4:00P M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | |
| Female | white | MONTH DAY YEAR
Apr. 2 1901 | 78 YRS. | | | IF UNDER 24 HRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| Washington, DC | | | USA | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | |
| Laurel | | | GREATER LAUREL BELTSVILLE HOSPITAL | | | Retired Receptionist | | |
| 13a. STATE | | | 13b. CITY OR TOWN | | | 13c. STREET ADDRESS | | |
| Maryland | | | Pr. Georges W. Laurel | | | 5815 Parkway Drive | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | |
| John | | | Ida | | | 16b. SOCIAL SECURITY NO. | | |
| 16c. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16d. SOCIAL SECURITY NO. | | | 17. INFORMANT | | |
| none | | | 412-14-5115 | | | Suzanne M. Maloney-dau-(same as 13e) | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4349 IMMEDIATE CAUSE (a) Cerebral Infarction

DOE TO, OR AS A CONSEQUENCE OF

(b)

DOE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | |
|---|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/9, 19 79, to 8/12, 19 79, that (I) (we) last saw the deceased alive on 8/11, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED | |
| Brian H. Avin | MD | 8/15/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS | | |
| Brian H. Avin | 6201 Greenbelt Rd. College Park MD | | |

| | | | |
|---|-----------|------------------------------------|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
| Burial | 8-15-1979 | Arlington National | Arlington Virginia |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | |
| Warner E. Pumphrey, Inc. | | AUG 16 1979 | |
| 8434 Ga. Ave., S.S. Md. | | 25b. REGISTRAR'S SIGNATURE | |
| | | Dorothy McCready | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) IDABELL B MEDLEY | | | | | 2a. DATE OF DEATH
MONTH 08 DAY 03 YEAR 79 | | | 2b. HOUR
11:55 AM | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH MAY DAY 28 YEAR 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGE'S COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PRINCE GEORGE'S GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
N/A | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
P. G. | | 13c. CITY OR TOWN
Suitland | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
6016 SURREY SQUARE LANE | |
| 14. FATHER'S NAME
FIRST JOHN MIDDLE LAST ALLEN | | | | 15. MOTHER'S MAIDEN NAME
FIRST ESTELLE MIDDLE LAST CLARK | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO.
216-38-6413 | | 17. INFORMANT
ADDRESS LANE, SUITLAND, MD.
JAMES R. MEDLEY SR./HUSBAND/6016 SURREY SQ. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure
2500
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Acute renal failure
DUE TO, OR AS A CONSEQUENCE OF (c) atrial fibrillation & Hypertension | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
weeks.
months.
years. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
Carcinoma, recto colon. | | | | | | | | | |
| 19a. DATE OF OPERATION
7/30/79 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Tracheostomy. | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
11:00 P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>
N/A | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/2 1979 to 8/3 1979 , that (I) (we) last saw the deceased alive on 8/2 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.) | | | | | | | | | |
| 22b. SIGNATURE
C. Soriano Jr. | | | | DEGREE
M.D. | | | | 22c. DATE SIGNED
8/3/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CESAR SORIANO JR. | | | | 22e. ADDRESS
119 Capital Heights Blvd.
Capital Heights, Md. 20027 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
AUG. 8, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
HARMONY CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
LANDOVER PG MARYLAND | | | |
| 24. FUNERAL DIRECTOR
NAME ROLLINS FUNERAL HOME, INC. ADDRESS 4339 HUNT PLACE, N. E. WASH. D.C. | | | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 7 1979 | | 25b. REGISTRAR'S SIGNATURE
Anthony McBrady | |

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

9 20770

1 - FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Marta C. Merrill | | | 2a. DATE OF DEATH MONTH DAY YEAR
August 5, 1979 | | 2b. HOUR
1:25P. |
| 3. SEX
female | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
April 15, 1883 | | 6. AGE (IN YEARS LAST BIRTHDAY)
96 years | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U S A | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince Georges | |
| 10. CITY OR TOWN OF DEATH
College Park | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
7013 Fordham Court | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
housewife | 12b. KIND OF BUSINESS OR INDUSTRY
home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
Md | 13b. COUNTY
Pro Georges | 13c. CITY OR TOWN
College Park | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
7013 Fordham Court | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Crowley | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Mason | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
219 54 9713 | | 17. INFORMANT ADDRESS
Julia S Merrill College Park, Md | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) aspiration - disordered medical examiner
436-
DUE TO, OR AS A CONSEQUENCE OF
(b) cerebro vascular accident
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 mo | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/21 , 19 79 , to 7/24 , 19 79 , that (I) (we) last saw the deceased alive on 7/24 , 19 79 , and that in (my) (our) opinion death occurred in the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
John R. Melnick | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
TTL DATE SIGNED
8/6/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
John R. Melnick | | 22e. ADDRESS
4400 Queensbury Rd Riverdale, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | 23b. DATE
Aug 6, 1979 | 23c. NAME OF SEPULCHRE OR CREMATORY
Ft Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Pro Georges Md. | |
| 24. FUNERAL DIRECTOR
NAME
F. Gasch's Sons P A Hyattsville, Md. | | | 25a. DATE REC'D. BY REGISTRAR
AUG 7 1979 | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DHMH - 17
(VR A15 ME (5))
30M 7/73

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 20771 | |
|--|--|--|--|---|--|---|--|--------------------------------------|--|--|--|
| FOR
1- STATE
REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Williams Donald MITCHELL Sr | | | | | | | | 8-5 1979 | | 150 A M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7. IF UNDER 1 YR. | | 7. IF UNDER 24 HRS. | |
| Male | | White | | NOV-7-38 | | 40 | | MONTHS DAYS | | HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. DATE PRONOUNCED DEAD | |
| MARYLAND | | U.S.A. | | WIDOWED | | DIVORCED | | Prince Georges MD | | 8-5 1979 | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| CHEVERLY | | PRINCE GEORGE HOSPITAL | | Manager | | Giant Food | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | |
| Maryland | | P.G. Co. | | Laurel | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 414 Montgomery St. | | | |
| 14. FATHER'S NAME | | | | | | | | | | | |
| FIRST | | MIDDLE | | LAST | | 15. MOTHER'S MAIDEN NAME | | FIRST | | LAST | |
| William | | H. | | Mitchell | | Lillian | | M. | | Bew | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | |
| No. | | 218-32-6178 | | Wm. H. Mitchell | | 9124 Grant Ave. | | Laurel, Md. | | 20810 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Multiple injuries with skull fracture | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? | |
| | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | | | | | | |
| UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 1550 A.M. 8-5 1979 | | Passenger ejected from car which crashed. | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | STREET FACTORY, FARM, ETC.) | | STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| | | Street | | Route 1 + Montgomery St. | | Laurel, P.G. Co., Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | MEDICAL EXAMINER | | DATE SIGNED | | | | | |
| August P. Rodriguez | | M.D. Rodriguez | | | | 8-5-79 | | | | | |
| EXAMINER'S NAME | | ADDRESS | | 5009 Bay View Court, Camp Springs | | | | | | | |
| (TYPE OR PRINT) | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | |
| (SPECIFY) | | 8/8/79 | | Ivy Hill Cemetery | | Laurel, P.G. Co., Maryland | | | | | |
| 24. FUNERAL DIRECTOR | | FLECK LAUREL FUNERAL HOME, INC. | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| | | 7601 Sandy Spring Rd. Laurel, Md. 20810 | | AUG 8 1979 | | [Signature] | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 60M 1/75
(VR A 15 (4))

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FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20772

| | | | | | | | | | |
|---|--|---|--|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Grace Mae Mobley | | | 2a. DATE OF DEATH
MONTH 8 DAY 4 YEAR 79 | | | 2b. HOUR
3:25 A.M. | | | |
| 3. SEX
Female | | 4. RACE
2 - white | | 5. DATE OF BIRTH
MONTH 5 DAY 12 YEAR 1900 | | 6. AGE (IN YEARS (LAST BIRTHDAY))
79 YRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Alabama | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince Georges MD. | | | |
| 10. CITY OR TOWN OF DEATH
Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)
Southern Md. Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Domestic | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE
Florida | | | | 13c. CITY OR TOWN
Escambia Pensacola | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
63 Penhaven Dr. | |
| 14. FATHER'S NAME
FIRST Unk. MIDDLE Unk. LAST Unk. | | | | 15. MOTHER'S MAIDEN NAME
FIRST Unk. MIDDLE Unk. LAST Unk. | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
267-96-6472 | | 17. INFORMANT
Jack D. Mobley, Accokeek, Md. 20607 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) lepsy
5990
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) unhappy heart infection
DUE TO, OR AS A CONSEQUENCE OF
(c) coronary artery | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hours
24 hours | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Profound ulcer, intestinal bleeding, Metastatic disease | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 10/5/75 to Aug 4 , 19 79 , that (I) (we) lost the deceased above, (I) (we) (did) not view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | |
| 22b. SIGNATURE
Ronald Landman MD | | | | | DEGREE
MD | | | 22c. DATE SIGNED
8/4/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Ronald Landman MD | | | | | 22e. ADDRESS
9401 Indian Head Hwy, Oxon Hill | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
8-7-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Memorial Pensacola Gardens | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Pensacola, Florida | | |
| 24. FUNERAL DIRECTOR
NAME
Hunt Funeral Home, Waldorf, Maryland | | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 10 1979 | | 25b. REGISTRAR'S SIGNATURE
P. H. H. H. | | |

BP



March 1941 4-7-41 Tennessee, Tennessee, Florida

March 1941 Home, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

DHMH - 16 50M 7/77
(VRA 15 (4))

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|--|---|---|----------------------------|--|
| 1. FOR STATE REGISTRAR | | 9 20773 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR - MIN | | |
| GLENN O. MORGAN | | | | | 8-12-79 | | 545 P.M. | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | |
| MALE | WHITE | JAN 10 12 | | 67 YRS. | | 8 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| MARYLAND | U.S.A. | | | | Prince Geo County MD. | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| LANHAM | MAGNOLIA Gardens | | | | Guard | | Prison | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13c. STREET ADDRESS | | |
| 13a. STATE Maryland 13b. COUNTY P.G. Co. 13c. CITY OR TOWN Laurel | | | | | | | 15312 Bond Mill Rd. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| William Robert Lee Morgan | | | | Rosa Fogle | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). DUE TO, OR AS A CONSEQUENCE OF (b). DUE TO, OR AS A CONSEQUENCE OF (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| Yes | | WWII | | 214-16-0087 | | Mrs. Betty J. Davenport | | Same as #13 | |
| 410- | | Acute Myocardial Infarction | | | | Immediate | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | Arteriosclerotic Vascular Disease | | | | 6 yr. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3 Sept 1976 to 12 Aug 1979, that (I) (we) lost saw the deceased alive on 12 Aug 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | 22c. DATE SIGNED | | | |
| Wm J. Winst MD | | | | | | 12 Aug 79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 8/14/79 | | Mt. Olivet Cemetery | | Frederick, Frederick Md | | | |
| 24. FUNERAL DIRECTOR | | | | 25. DATE RECD BY REGISTRAR | | | | | |
| FLACK LAUREL FUNERAL HOME, INC. | | | | AUG 14 1979 | | | | | |
| 7601 Sandy Spring Rd. Laurel, Md. 20810 | | | | | | | | | |

24. FUNERAL DIRECTOR

FLACK LAUREL FUNERAL HOME, INC.
7601 Sandy Spring Rd. Laurel, Md. 2081025. DATE RECD BY REGISTRAR
AUG 14 1979

2010



Handwritten notes and a table on lined paper. The table has several columns and rows, with some text written in the cells. The handwriting is somewhat faded and difficult to read.

Handwritten notes and a table on lined paper. The table has several columns and rows, with some text written in the cells. The handwriting is somewhat faded and difficult to read.

Handwritten notes and a table on lined paper. The table has several columns and rows, with some text written in the cells. The handwriting is somewhat faded and difficult to read.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled without delay with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the body must be examined.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|---|--|
| 1. FOR
STATE
REGISTRAR | | 79 20774
REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST <u>Virginia</u> MIDDLE
<u>Grace V. Morris</u> | | | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>Caucasian</u> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<u>6/19/98</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>81</u> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>West Virginia</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Prince Georges</u> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
<u>Accokeek</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>15755 Livingston Road</u> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>Housewife</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
<u>Maryland</u> | | 13b. COUNTY
<u>Prince Georges</u> | | 13c. CITY OR TOWN
<u>Accokeek</u> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<u>15755 Livingston Road</u> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<u>Isaac Newton Kennedy</u> | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<u>Lillian Levelle</u> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>NO</u> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<u>232-22-2064</u> | | 17. INFORMANT
ADDRESS
<u>James Fred Morris same as 13</u> | | | | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>
<u>410-</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>General Arteriosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(c) <u>years</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>6 hrs.</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>1. Hypertension, years 2. Congestive Heart Failure, years</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/23/55</u> , 19____, to <u>8/15/79</u> , 19____, that (I) (we) last saw the deceased alive on <u>8/15/79</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Paul Chen</u> | | | | DEGREE
<u>M.D., F.A.A.F.P.</u> | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>8/16/79</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Paul Chen, M.D., F.A.A.F.P.</u> | | | | 22e. ADDRESS
<u>Wilson Memorial Clinic</u>
<u>Accokeek, Maryland 20607</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>Aug. 18, 1979</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Trinity Mem. Gar. Waldorf, Charles, Md.</u> | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<u>Huntt Funeral Home Waldorf, Maryland</u> | | | | 25a. RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
<u>Aug 20 1979</u> <u>[Signature]</u> | | | | | | | |

2:30 P

8/12/79

Grace V. Morris

81

6/19/98

Caucasian

Female

Prince Georges

U.S.

Houswife

Accokeek

Box 419

X

Prince Georges Accokeek

Maryland

Coronary Thrombosis

General Atherosclerosis

1. Hypertension, years 2. Congestive Heart Failure, years

8/12/79

12/23/55

8/12/79

8/16/79

M.D., F.A.A.P.

Wilson Memorial Clinic
Accokeek, Maryland 20607

Paul Chen, M.D., F.A.A.P.

Item 5g535 9/6/79 g3

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

9 20775

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Estelle (NMI) Morsell | | | 2a. DATE OF DEATH
MONTH DAY YEAR
August 24, 1979 | | | 2b. HOUR
5:37a.m. | | | | |
| 3. SEX
Female | | 4. RACE
Negro | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 09 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
YRS | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 9. CITIZEN OF WHAT COUNTRY?
USA | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
Prince George's MD. | | | | |
| 12. CITY OR TOWN OF DEATH
Lanham | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Doctors' Hospital of Pr. Geo. Co. | | | | 14. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 15. KIND OF BUSINESS OR INDUSTRY | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Calvert | | | 13c. CITY OR TOWN
Chesapeake Beach | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Crompton Jones | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie Forster | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | | | |
| 17. SOCIAL SECURITY NO
214-38-5779 | | | 18. INFORMANT ADDRESS
Roland Morsell Box 141 Chesapeake Beach, Md. | | | | | | | |

| | | | |
|---|--|--|--|
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrest
2503
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Uremia
(c) Chronic Nephropathy | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
|---|--|--|--|

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (i) (this hospital) attended the deceased from 8/6 1979 to Aug 23 1979 , that (i) (we) last saw the deceased alive on Aug 23 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) see the body after death. | | | | | | | |
| 22b. SIGNATURE
Benjamin S. Pecson | | | | DEGREE | | 22c. DATE SIGNED
24 Aug 79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BENJAMIN S. PECSON, M.D. | | | | 22e. ADDRESS
6106 Old Silver Hill Road, District Heights, Md. | | | |

| | | | | | | | |
|--|--|--------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Aug. 27-79 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Edmonds Chr. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Chesapeake Beach Cal., Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Spencer E. Sewell Box 31 Prince Frederick | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 28 1979 | | 25b. REGISTRAR'S SIGNATURE
Robert H. Boney | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

115

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Department of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 7 20776 | |
|--|--|--|--|---|--|---|--|--|------------------------------|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
Charles Douglas Morton | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
Aug. 27 1979 | | | 2b. HOUR
5:45 P.M. | | |
| 3 SEX
Male | | 4 RACE
white | | 5 DATE OF BIRTH MONTH DAY YEAR
April 7, 1914 | | 6 AGE (IN YEARS LAST BIRTHDAY)
65 years YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington D C | | 7b. CITIZEN OF WHAT COUNTRY?
U S A | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Prince Georges MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Cheverly | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Prince Georges General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Meat cutter | | 12b. KIND OF BUSINESS OR INDUSTRY
Retired | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md 13b. COUNTY Pro Georges 13c. CITY OR TOWN New Carrollton 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | 13e. STREET ADDRESS
8318 Nicholson Street | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Alfred Robert Morton | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Susan Funk | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
no | | | | 16b. SOCIAL SECURITY NO.
212 09 5453A | | 17 INFORMANT ADDRESS
Amelia Allen Morton New Carrollton, Md. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute cardiac arrest
4029
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertension or cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Right lung carcinoma | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 24 , 19 79 , to 8/27 , 19 79 , that (I) (we) lost saw the deceased alive on 8/27/79 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 8/28/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr David Anderson | | | | 22e. ADDRESS
3308 Dodge Park Rd Landover, Md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
Aug 30, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Suitland Pro Georges Md. | | | |
| 24. FUNERAL DIRECTOR NAME
F. Gasch's Sons P A ADDRESS
Hyattsville, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 31 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

100-100000

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

| | | | | | |
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| 100-100000 | 100-100000 | 100-100000 | 100-100000 | 100-100000 | 100-100000 |
| 100-100000 | 100-100000 | 100-100000 | 100-100000 | 100-100000 | 100-100000 |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL EXAMINER. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
15M 7/77

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 20177 | | |
|---|-------------------------|---|---|---|---|---|--|--|--|---|--|--------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) HARRISON MORTON | | | | | | | | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
8-22 1979 | | 2b. HOUR
M
A |
| 3. SEX
Male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
7-26-13 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
YRS.
66 | IF UNDER 1 YR.
MONTHS DAYS
1 | IF UNDER 24 HRS.
HOURS MIN
5 | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
8-22 1979 | | 2d. HOUR
M
A | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel | | | | | | |
| 10. CITY OR TOWN OF DEATH
CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PRINCE GEORGE GEN. HOSP. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. GOV'T. | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | |
| 13a. STATE
MD. | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
CHAPEL OAKS | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1301 CHAPEL LN. | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
HARRISON MORTON SR. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
JULIA CARTER | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
YES | | (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO.
579 01-0586 | | 17. INFORMANT ADDRESS
SALLY MORTON - SAME AS #13 ABOVE | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Cardiovascular disease
4292
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusto P. Rodriguez | | | | TITLE (SPECIFY)
M.D. Deputy MEDICAL EXAMINER | | | | DATE SIGNED 8-22-79 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D. | | | | ADDRESS 5009 Rayburn Ct., Camp Springs, Md. 20031 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE
8-28-79 | | 23c. NAME OF CEMETERY OR CREMATORY
CHELTENHAM NATL. CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
CHELTENHAM, P.G. MD. | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
H.S. WASHINGTON + SONS | | | | ADDRESS
4125 BURROUGHS AVE. N.E. | | 25. DATE RECEIVED BY REGISTRAR
AUG 28 1979 | | 26. REGISTRAR'S SIGNATURE
[Signature] | | | | |

BP

1111

AMOUNT EXHAUSTED IN THE YEAR



10
5
1/2

10 4 9

Aug 3 1899

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|---|---|---|--|--|---|---|--|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. 20778 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
Joseph Reginald Mudd | | | 2a. DATE OF DEATH
August 23, 1979 | | | | 2b. HOUR
7:30 A.M. | | | |
| 3. SEX
Male | | 4. RACE
Cau. | | 5. DATE OF BIRTH
June 21, 1930 | | 6. AGE (IN YEARS LAST BIRTHDAY)
49 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince Georges MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Cheverly | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Prince Georges Gen. Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Inspector | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | | | 13b. CITY OR TOWN
Charles | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS
Rt. #1 Box 117 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Francis Raymond Mudd, Sr. | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emma Eugenia Brent | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
Korean | | 17. INFORMANT ADDRESS
218-26-6610 E. Gwynn Mudd Waldorf, Maryland | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) aspiratory failure
2030
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) hypertension
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/15/79 to 8/23/79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Lewis Dennis, M.D. | | | | 22c. DATE SIGNED
8-23-79 | | | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
Lewis Dennis, M.D. | | | | 22f. ADDRESS
831 University Blvd. E. Silver Spring, Maryland | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
8-25-79 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Peter's Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Waldorf, Charles, Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
The Huntt Funeral Home, Waldorf, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 29 1979 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | |



Joseph W. Smith, 1840-1856

1840-1856

1856-1860

1860-1864

1864-1868

1868-1872

1872-1876

1876-1880

1880-1884

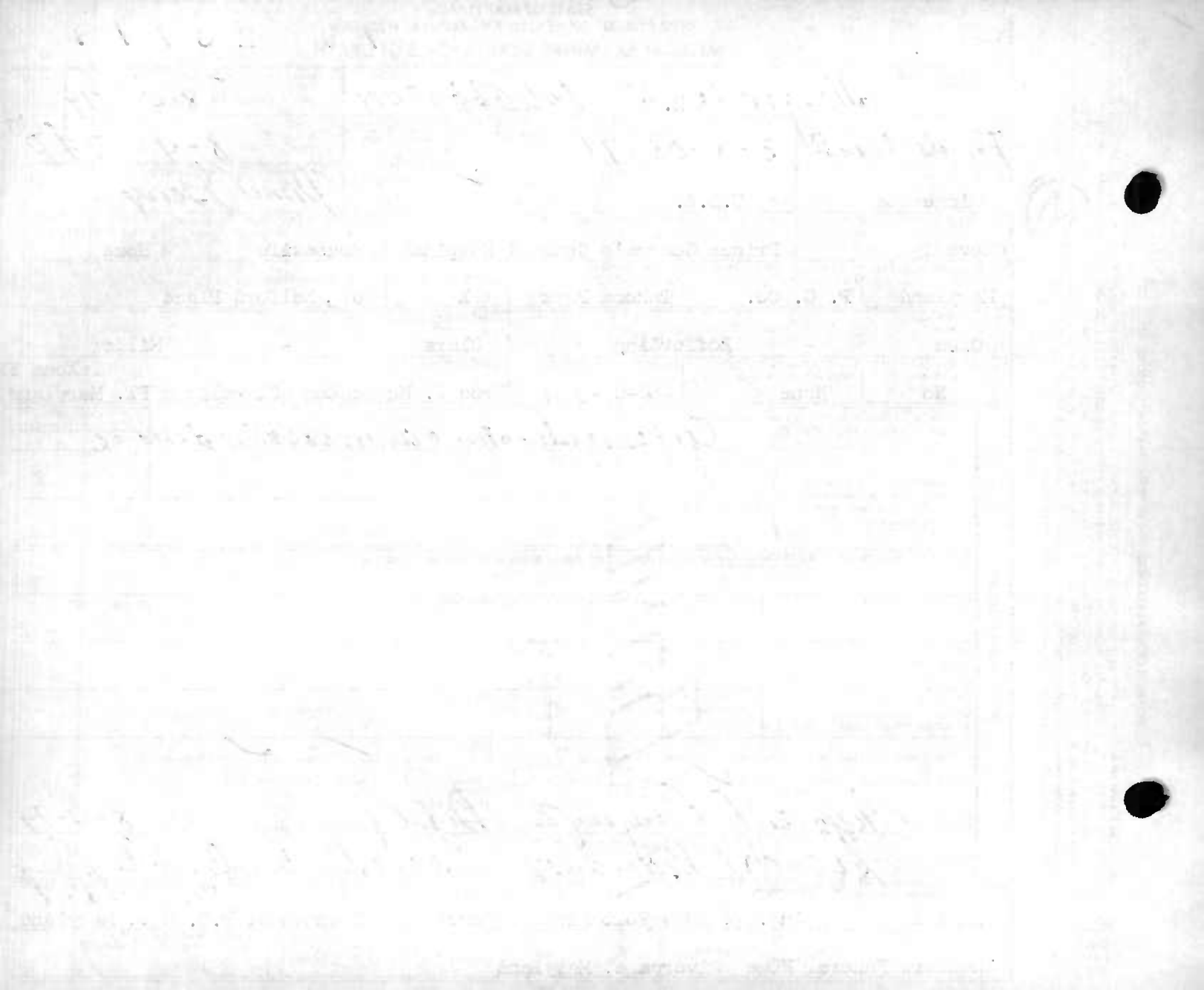
1884-1888

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 1, 2, AND 3. RETAIN PAGE 4 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
30M 7/73

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 20779
REG. NO. | |
|---|--|----------------------|--|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) MARJORIE B. MUGLESTON | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> 8-4 19 79 | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH 3-8-08 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD. | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | |
| 13a. STATE Maryland | | | | 13b. COUNTY P. G. Co. | | 13c. CITY OR TOWN Takoma Park | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 401, Belford Place | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Clem - Bofferding | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara - Miller | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. None | | 17. INFORMANT ADDRESS Takoma Pl | | | | | |
| | | | | 468-07-3257 | | Fred W. Mugleston 401 Belford Pl. Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary atherosclerotic cardiovascular disease
4292
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-lying cause last</u> .
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE August P. L... .. | | | | TITLE (SPECIFY) Deputy M.D. | | | | MEDICAL EXAMINER DATE SIGNED 8-4-79 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) August P. L... | | | | ADDRESS 5009 Rayburn Court, Camp Springs | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE Aug. 7, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | | | | 23d. LOCATION CITY OR TOWN Brentwood, P.G. Co., Maryland | |
| 24. FUNERAL DIRECTOR NAME Chambers Funeral Home | | | | ADDRESS Riverdale, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR AUG 09 1979 | | 25b. REGISTRAR'S SIGNATURE ... | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 7 9 2 0 7 8 0
REG. NO. | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Julia Maureen Murray | | | | 2a. DATE OF DEATH MONTH DAY YEAR
August 11 1979 | | | | 2b. HOUR
8:30 PM | | | | | |
| 3 SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
March 10 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Hallstead, PA | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince Georges MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
UNIVERSITY PARK MARYLAND | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4103 SHERIDAN STREET | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE
Florida | | | | 13b. COUNTY
Dade | | 13c. CITY OR TOWN
Miami | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
7865 S.W. 128th Street | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Bernard J. Allen | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary E. O'Day | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
264-23-2361 | | 17. INFORMANT ADDRESS
ANNE HODWORTH 4103 SHERIDAN STREET UNIVERSITY PARK, MARYLAND | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis
1531
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of transverse colon
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 MONTHS
2 YEARS | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
Oct. 6, 1978 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED color
Inoperable carcinoma, transverse | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from October 6, 1978, to August 11, 1979, that (I) (we) last saw the deceased alive on August 11, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Frank J. Sanzaro, M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
August 11, 1979. | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Frank J. Sanzaro, M. D. | | | | 22e. ADDRESS
2001 Eye Street, N.W., Suite 305 Washington, D. C. 20006 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
8-14-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Calvary Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Johnston City Broome N.Y. | | | | | |
| 24. FUNERAL DIRECTOR NAME
Francis J. Collins | | | | 24b. ADDRESS
500 University Blvd. West Silver Spring, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 15 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

BP

Prince George

Johnson City, N.Y.

February 1970

1-14-70

General

500 University Blvd. West Silver Spring, Md.
Francis J. Collins

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20781

1. FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | |
| FIRST MIDDLE LAST
Roy ANGELO NELSON | | | MONTH DAY YEAR
08 15 79 | | | HOUR MIN.
1:20p | | | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | |
| Male | | Caucasian | | MONTH DAY YEAR
11 09 03 | | 75 YRS | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Texas | | USA | | | | Prince Georges County MD | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Clinton | | SOUTHERN MARYLAND HOSPITAL CENTER | | Parole Officer | | D.C. Gov't | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13b. CITY OR TOWN | | | 13c. STREET ADDRESS | | | 13d. INSIDE CITY LIMITS? | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. STREET ADDRESS | | | 13d. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Washington D.C. | | | | | | 3014 Gainsville St., S.E. | | | | |
| 14 FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST
Louis Nelson | | | FIRST MIDDLE LAST
Frances Sparks | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT (spouse) ADDRESS | | | | |
| Yes | | | WWII | | | Ruth Shirley Nelson Same as #13 | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line (a), (b), and (c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Left Middle Cerebral Artery Thrombosis</i>
4292 } DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which }
gave rise to immediate }
cause (a), stating the }
underlying cause lost }
(b) <i>Chronic atherosclerotic Cardiovascular Disease</i>
} DUE TO, OR AS A CONSEQUENCE OF
(c) <i>5 years</i> | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>2 weeks</i> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I
<i>Carcinoma, left maxillary sinus</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8-15-79</i> to <i>8-15-79</i> , that (I) (we) lost
saw the deceased alive on <i>8-15-79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) did (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Thomas F. Cleary M.D.</i> | | | 22c. ADDRESS
<i>9131 Piscataway Rd., Clinton, Md.</i> | | | 22d. DATE SIGNED
<i>8-15-79</i> | | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
Thomas F. Cleary, M.D. | | | 22f. ADDRESS
9131 Piscataway Rd., Clinton, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| Burial | | | Aug 17, 1979 | | | Cedar Hill Cem | | | Suitland PG Md | |
| 24 FUNERAL DIRECTOR
NAME | | | 24b. ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Robert E. Wilhelm
Funeral Home Inc | | | Suitland, MD | | | AUG 21 1979 | | <i>Robert E. Wilhelm</i> | | |

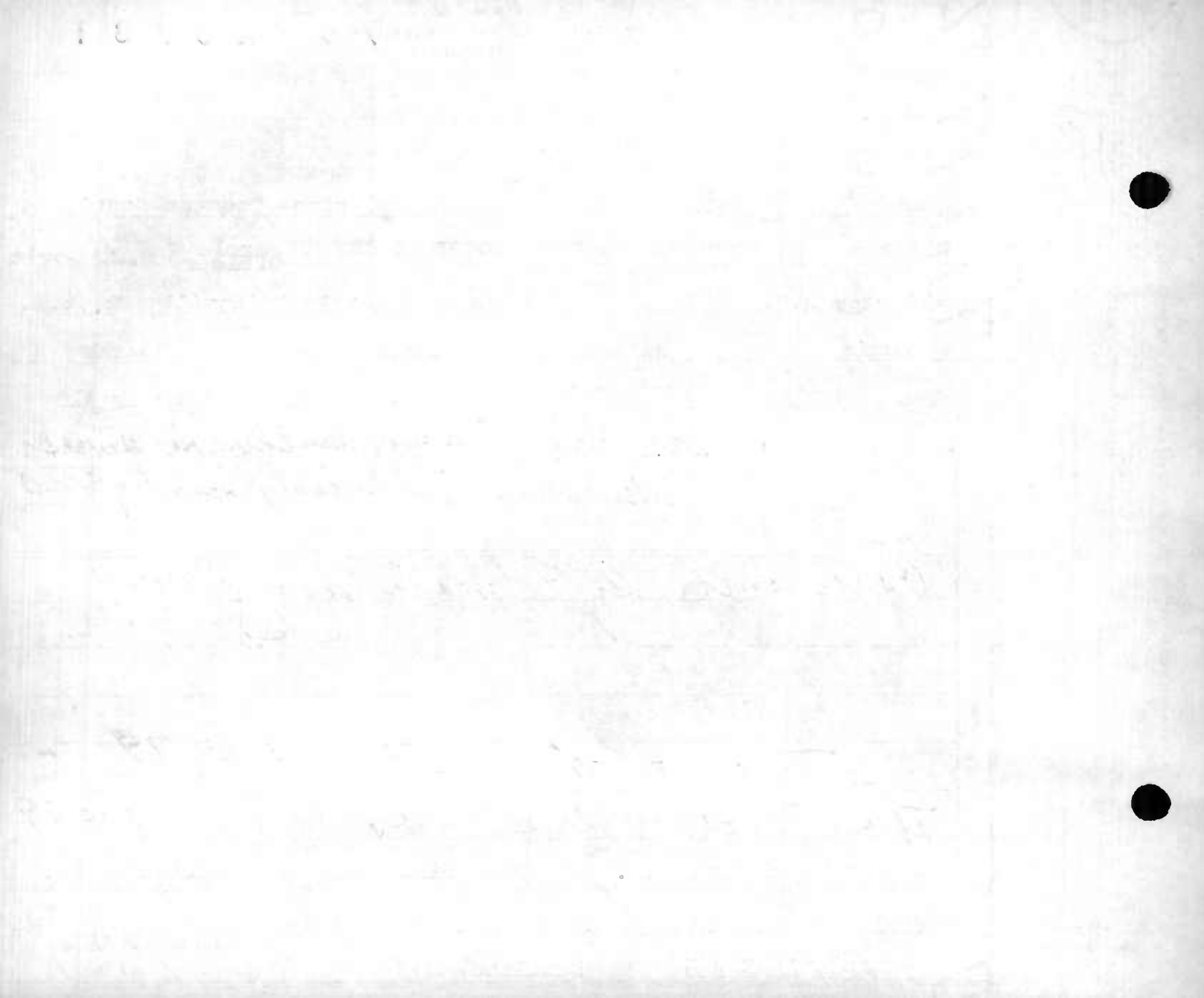
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 20782 | |
|--|--|------------------|--|--|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Octavia Constance Nix | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
8 3 1979 | | 2b. HOUR
M
4:20P | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 18 78 | | 6. AGE (IN YEARS)
LAST BIRTHDAY
YRS. MONTHS DAYS
11 | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
8 3 1979 | | 7d. HOUR
M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince George's County, MD. | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Andrew's Air Force Base Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
None | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Forestville | | | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
6519 Hill-Mar Drive | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Dyrrel Cobs | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Valencia Nix | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
no | | | | 16b. SOCIAL SECURITY NO.
213 90 1825 | | 17. INFORMANT ADDRESS
Valencia Nix-mother-6519 Hill-Mar Drive | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome
7980
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE
Thomas D. Smith, M.D. | | | | TITLE (SPECIFY)
Deputy Chief | | | | DATE SIGNED
8/4/79 | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Thomas D. Smith, M.D. | | | | ADDRESS
111 Penn St. Balto. MD | | | | | | | |
| 23a. BURIAL, CREMATION, OR REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
8/9/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Maryland National | | 23d. LOCATION
Laurel, Maryland | | STATE | |
| 24. FUNERAL DIRECTOR
NAME
Stewart | | | | 25a. DATE REC'D. BY REGISTRAR
NE. AUG 15 1979 | | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

U.S. AIR FORCE



10-10-11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. 9 20783 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
BARBARA S NOBLE | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
08 19 79
2b. HOUR
12:11P M | | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
Mar. 22, 1931 | | 6. AGE (IN YEARS LAST BIRTHDAY)
48 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGES MD. | | | |
| 10. CITY OR TOWN OF DEATH
CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PRINCE GEORGES GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY
Hillside | | 13c. CITY OR TOWN
P.G. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1212 Elfin Avenue | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Carl M. Smith, Sr. | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary M. Smith | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
235 48 4654 | | 17. INFORMANT ADDRESS
1212 Elfin Avenue
Richard H. Noble-Husband | | Hillside, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>BRAIN DEATH</u>
431-
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE RESPIRATORY ARREST</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) <u>MASSIVE CEREBRAL & CEREBELLAR HEMORRAGE</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Ronald P. Hairston</i>
DEGREE | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
20785 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RONALD P. HAIRSTON, MD | | | | | 22e. ADDRESS
6910 COLUMBIA PK RD LANDOVER, MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial- | | 23b. DATE
8/25/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenlawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Clarksburg, West Virginia | | | |
| 24. FUNERAL DIRECTOR
NAME
Stewart Funeral Home-4001 Benning Road, NE | | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 27 1979 | | 25b. REGISTRAR'S SIGNATURE
<i>Henry McCreedy</i> | | |

MEDICAL CERTIFICATION

9
9

1

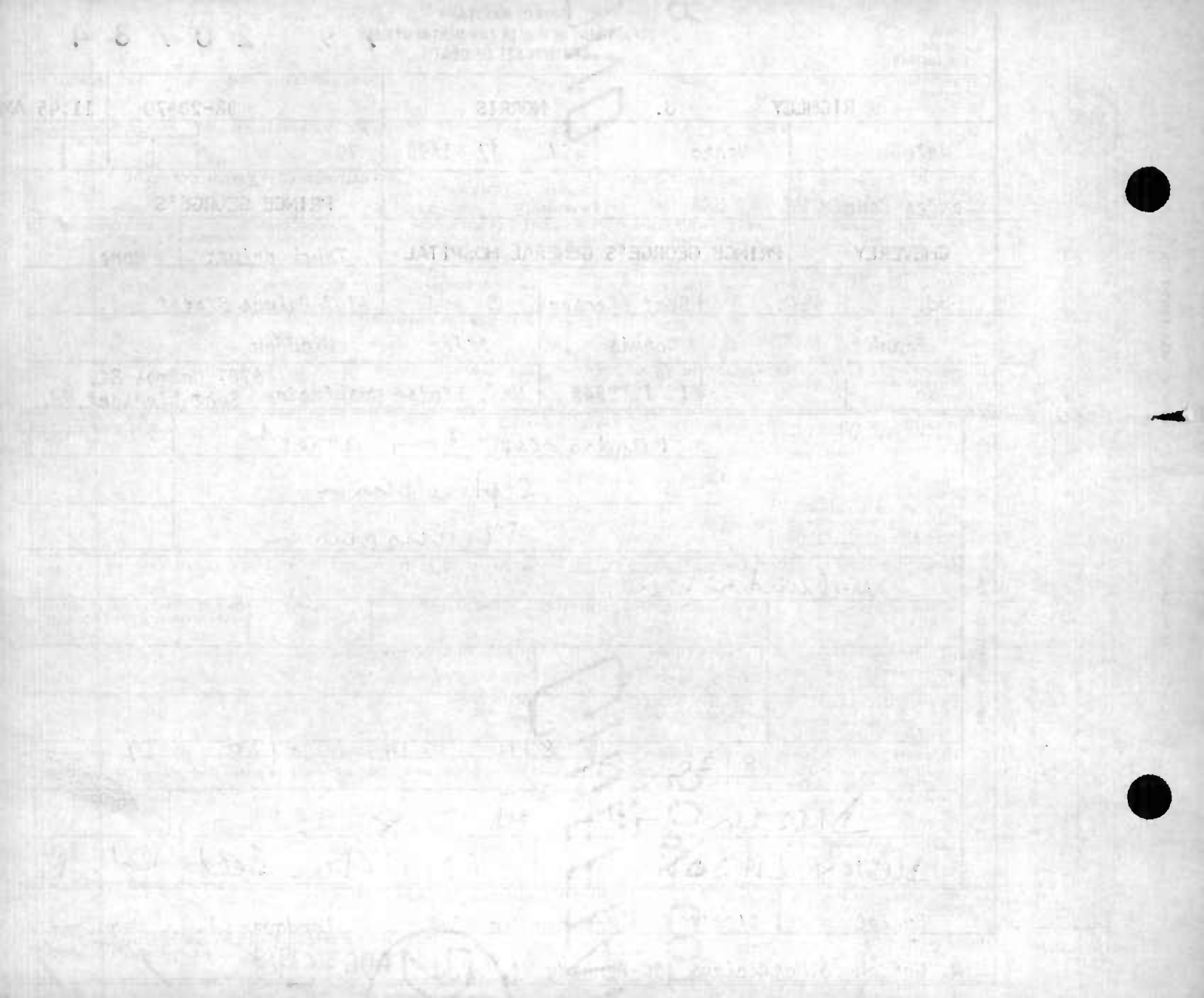
BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|--------------------------------------|--|--|
| FOR
1 - STATE REGISTRAR | | | | | REG. NO. 9 20784 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
RICHLEY J. NORRIS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
08-20-79 | | | 2b. HOUR
11:45 AM | |
| 3. SEX
Male | | 4. RACE
Negro | | 5. DATE OF BIRTH
MONTH DAY YEAR
9/7 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Charles County Md | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGE'S MD. | | | |
| 10. CITY OR TOWN OF DEATH
CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PRINCE GEORGE'S GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Truck driver | | 12b. KIND OF BUSINESS OR INDUSTRY
None | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
Seat Pleasant | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
6707 Calmos Street | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank Norris | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alice Gladden | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
212 12 9348 | | 17. INFORMANT ADDRESS
Mrs. Eloise Washington 6707 Calmos St.
Seat Pleasant, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) cardio respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Septicemia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Pneumonia
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
malnutrition | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/11, 19 79, to 8/20, 19 79, that (I) (we) lost saw the deceased alive on 8/20, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Susan Lajda MD | | | | | DEGREE
MD | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SUSAN LAJDA MD | | | | | 22e. ADDRESS
6201 Greenbelt Rd. Blk. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
8/24/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Harmony Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Landover P.G. Maryland | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
R.N. Horton Co. Morticians 600-Kennedy St. N.W. | | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 27 1979 | | 25b. REGISTRAR'S SIGNATURE
Horton | | |



8/9 Released by Medical Examiner to
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be
received by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3
should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director after death
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 9 20785 | |
|---|--|---|--|---|--|---|--|---|--|--|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
EDWARD | | MIDDLE
L. | | LAST
NORTON | | 2a. DATE OF DEATH
MONTH DAY YEAR
08-09-79 | | 2b. HOUR
9:47AM | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
MARCH 17, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 7b. IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN
COUNTRY)
WASH., D. C. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGE'S COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PRINCE GEORGE'S GENERAL HOSPITAL | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
ELECTRICIAN | | 12b. KIND OF BUSINESS OR
INDUSTRY
FEDERAL GOV. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | 13b. COUNTY
PR. GEORGE | | 13c. CITY OR TOWN
HILLSIDE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5003 GUNTHER STREET | | | |
| 14. FATHER'S NAME
JAMES | | 15. MOTHER'S MAIDEN NAME
ZILPHIA | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
578-14-4328 | | 17. INFORMANT
ADDRESS
JOHN L NORTON 3917 TRITON COURT MaARLO HGTS MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary insufficiency</u>
4029
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Hyper-tensive cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Cerebro-vascular insufficiency</u> | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
year, | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>Cerebro-vascular insufficiency</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>none</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. <u>N.A.</u> 19 <u>79</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
<u>N.A.</u> | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/6</u> 19 <u>79</u> , to <u>8/9</u> 19 <u>79</u> , that (I) (we) last
saw the deceased alive on <u>3</u> <u>was</u> <u>and</u> <u>and</u> that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (If we (I) did not view the body after death.) | | | | | | | | | | | |
| 22b. SIGNATURE
<u>C. Soriano</u> | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
<u>8/9/79</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>CESAR SORIANO JR. MD.</u> | | 22e. ADDRESS
<u>119 Capital Heights Blvd.</u>
<u>Capital Heights Md. 21027</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
8/13/79 | | 23c. NAME OF CEMETERY OR CREMATORY
FT. LINCOLN CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BRENTWOOD PR. GEO. MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR
NAME
GEORGE P KALAS FUNERAL HOME | | ADDRESS
6250 OXON HILL RD
OXON HILL MARYLAND | | DATE REC'D. BY REGISTRAR
AUG 13 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>Harry McCreedy</u> | | | | | |

Charles E. Neal Exam. Dr. Rodriguez
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/73
 (VRA 15 (4))

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO.

9 20186

1. FOR
 STATE
 REGISTRAR

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Donald Carson PALMER | | | 2a. DATE OF DEATH
MONTH 8 DAY 16 YEAR 79 | | | 2b. HOUR
2:41 PM | | | | | |
| 3. SEX
MALE | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 10 DAY 30 YEAR 15 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGES MD | | | | | |
| 10. CITY OR TOWN OF DEATH
Lanham | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Doctors Hospital of P.G. County | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Milkman | | | 12b. KIND OF BUSINESS OR INDUSTRY
Dairy | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Pri. Georges | | 13c. CITY OR TOWN
New Carrollton | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
7203 Longbranch Drive | | | |
| 14. FATHER'S NAME
FIRST Robert MIDDLE LAST Palmer | | | | 15. MOTHER'S MAIDEN NAME
FIRST Pauline MIDDLE LAST Parisot | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) yes | | | | 16b. SOCIAL SECURITY NO.
WW 11 | | 17. INFORMANT
ADDRESS New Carrollton,
Joyce Hinkley, 7203 Longbranch Dr., Maryland | | | | | |

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST.
441/3
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(b) Ruptured Abdominal Aneurysm.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
16 hours | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)
Chronic Obstructive Pulmonary Disease Congestive Heart Failure | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 19, 1978 , to Aug 16, 1979 , that (I) (we) last saw the deceased alive on Aug 16, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Morton A. H. Schuler MD | | | | | | DEGREE
MD | | 22c. DATE SIGNED
8-16-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Morton A. H. Schuler MD | | | | | | 22e. ADDRESS
1299 LAMBERTA DR S. LINDSBURG MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Aug. 20, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Clarks Green Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Clarks Green, Penna. | | | |
| 24. FUNERAL DIRECTOR
Robert G. Beall Funeral Home ADDRESS
9013 Annapolis Road, Lanham, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 22 1979 | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
R. J. McCreedy | | | |

24. FUNERAL DIRECTOR
 Robert G. Beall Funeral Home ADDRESS
 9013 Annapolis Road, Lanham, Maryland

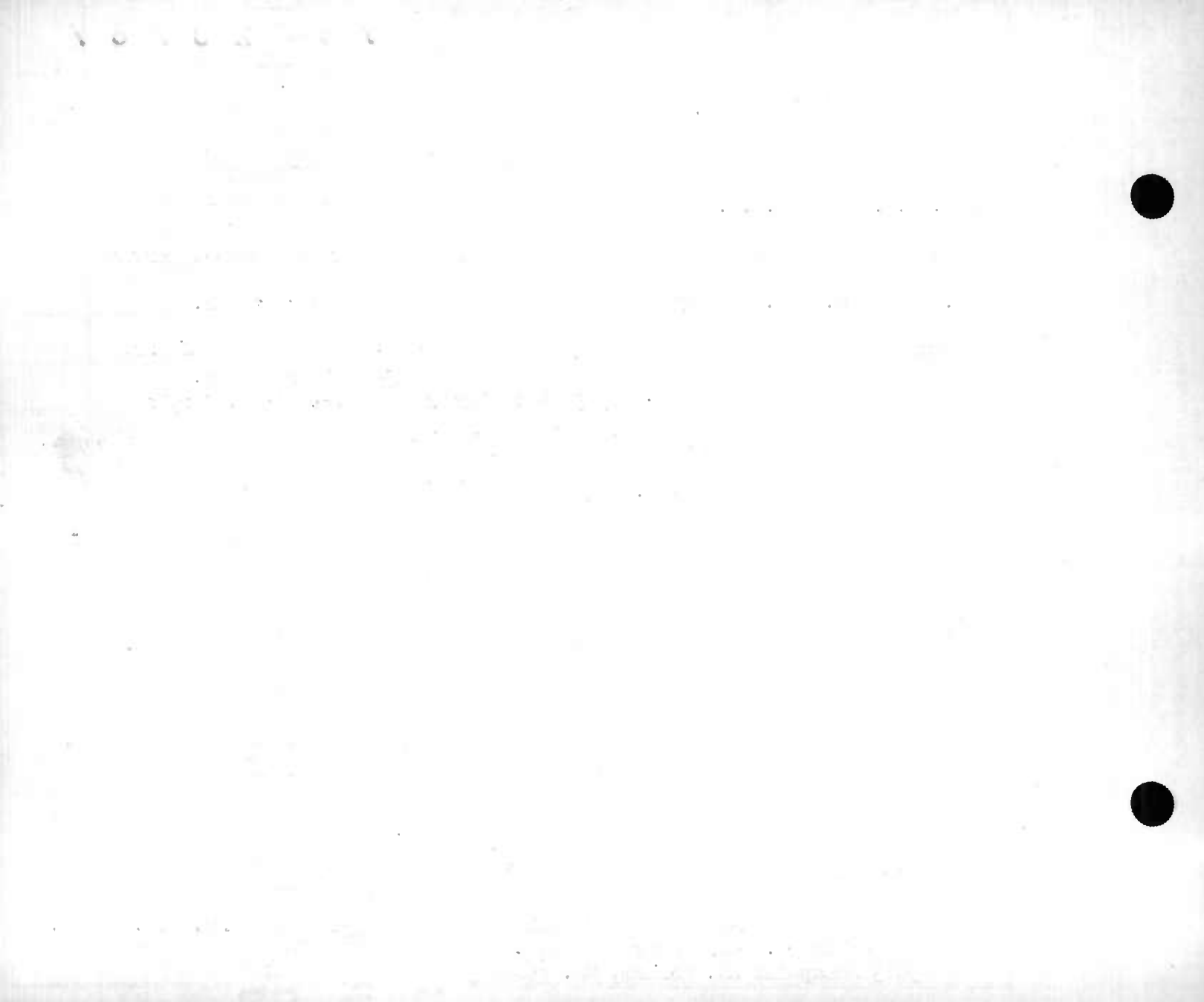
25a. DATE REC'D. BY REGISTRAR
 25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | REG. NO. 9 20787 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
NITA L. PARKER | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
AUGUST 9, 1979 | | | 2b. HOUR
10:15A _M | | |
| 3 SEX
Female | | 4 RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
7- 31- 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY)
53 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince George's MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Lanham | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Doctors' Hospital of Pr. Geo. Co. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Internal Revenue | | 12b. KIND OF BUSINESS OR INDUSTRY
Services | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | | | 13b. CITY OR TOWN
Pr. Geo. | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
168 West Way Dr. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Harry Reid | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Elizabeth Hubart | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
577-48-5353 | | 17. INFORMANT ADDRESS
5134 Flintbridge Dr.
Reid Parker Hyattsville, Maryland | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) <u>Renal & respiratory failure</u>
5-86-
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>marked obesity</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Sepsis</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6-9-79 →
8-9-79 | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Possible diffuse intravascular coagulopathy</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>Thrombectomy attempted 8-9-79</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Obstruction, interperitoneal catheter for dialysis</u> | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-09-79</u> to <u>8-9-79</u> , that (I) (we) last saw the deceased alive on <u>8-9-79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Rafael C. Lee, M.D.</u> | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
8/9/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Rafael C. Lee, M.D. | | | | | 22e. ADDRESS
9410 Brandywine Road, Clinton, Md. 20735 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
8-11-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland Pr. Geo. Md. | | | | |
| 24. FUNERAL DIRECTOR NAME
Robert G. Beall Funeral Home | | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 13 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |
| 26. ADDRESS
9013 Annapolis Rd. Lanham, Md. <u>Vari</u> | | | | | | | | | | |





FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

9 20788

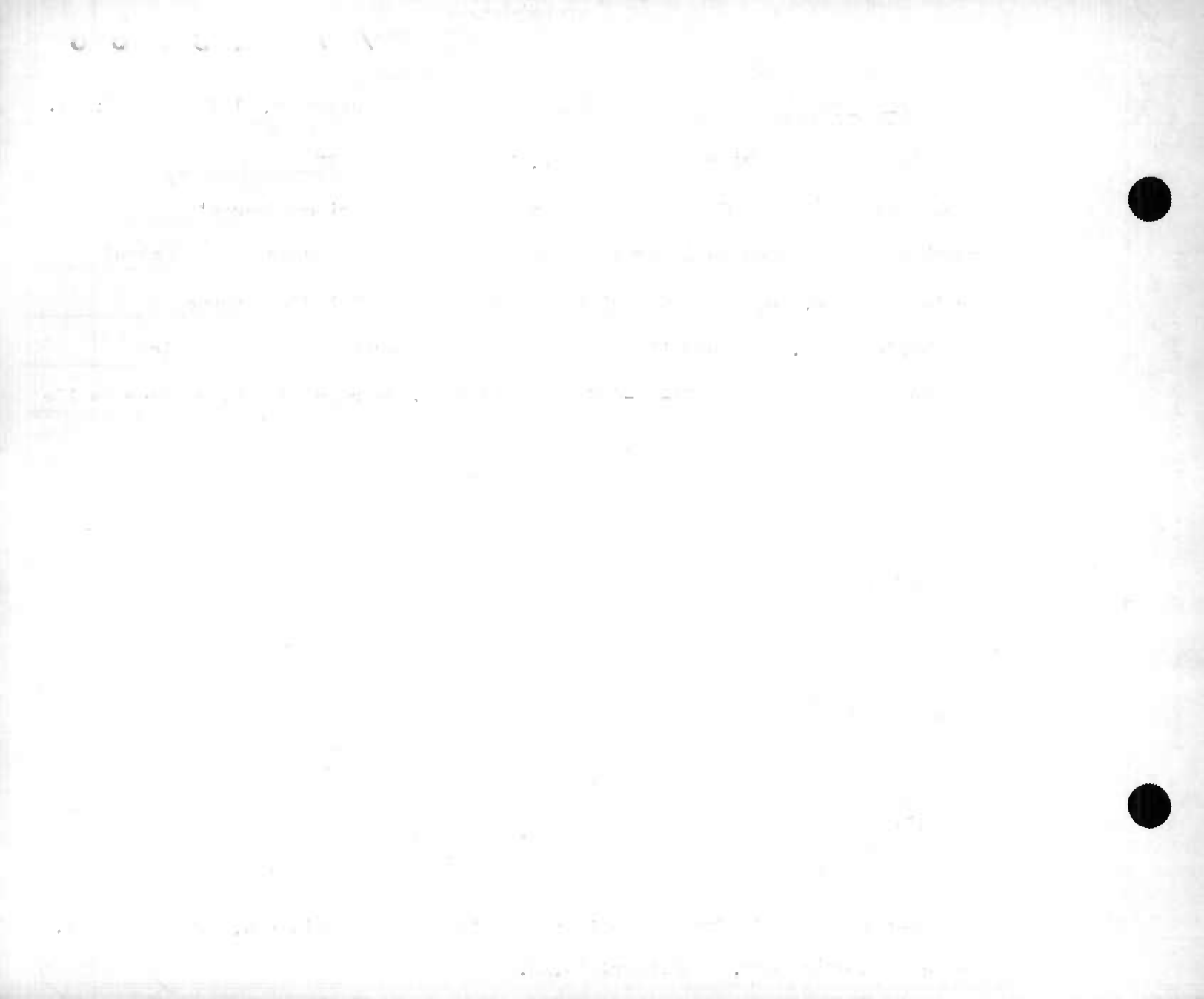
| | | | | | | |
|---|--|---|--|--|-----------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) GLADYS K PAVLAT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
August 9, 1979 | | 2b. HOUR
3:20A. M | |
| 3 SEX
Female | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec 1, 1895 | | |
| 6 AGE (IN YEARS LAST BIRTHDAY)
83 YRS | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Nebraska | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | |
| 8. BALTIMORE CITY OR COUNTY OF DEATH
Prince George's MD. | | 9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 10. CITY OR TOWN OF DEATH
Greenbelt | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Greenbelt Nursing Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY
School | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Pr. Geo's | | 13c. CITY OR TOWN
Hyattsville | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles A. Kendall | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bertha Rice | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | |
| 16b. SOCIAL SECURITY NO.
578-48-6375 | | 17. INFORMANT
ADDRESS
Shirley P. Pearson (daughter) same as 13e | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma
DUE TO, OR AS A CONSEQUENCE OF
(b) Cancer Rectum
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Cancer about breast | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/12 , 19 78 , to 8-9 , 19 79 , that (I) (we) last saw the deceased alive on 2/21 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
[Signature] | | DEGREE
MD | | 22c. DATE SIGNED
8/9/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
T. SURY | | 22e. ADDRESS
6490 Loddock Rd Loddock | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
8/13/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Nat'l Cem | | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington, Arlington Va. | | 25a. DATE REC'D. BY REGISTRAR
AUG 13 1979 | | | | |
| 24. FUNERAL DIRECTOR
NAME
Francis Gasch's Sons, PA | | ADDRESS
Hyattsville, Md. | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

64
90
35
64
1
2
9
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1. FOR REGISTRAR
1 - STATE REGISTRAR | | | | | 7 9 2 0 7 8 9
REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MARY MIDDLE E. LAST PAYNE | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
8-21-79
2b. HOUR
4:20 AM | | | | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
June 23 1891 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wales | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince George's MD. | | | |
| 10. CITY OR TOWN OF DEATH
Forestville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Regency Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13a. STREET ADDRESS | | | | |
| 13a. STATE
Md. | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
Hillcrest Hgts | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Martin J. Pardey | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Annie Jones | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
192-05-6393 | | 17. INFORMANT ADDRESS
Leonard P. Payne, Son, Same as Above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute Cardiac Failure</i>
4292
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Advanced Arterio Sclerotic Cardio Vascular Disease</i>
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>17 July</i> 19 <i>79</i> , to <i>17 Aug</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>17 July</i> 19 <i>79</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Benjamin S. Peckson</i> | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
<i>21 Aug. 79</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BENJAMIN S. PECKSON, M.D.
6106 OLD SILVER HILL RD., S. E. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
8-24-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland, P.G., Maryland | | | |
| 24. FUNERAL DIRECTOR NAME
Robt E Wilhelm | | | | | ADDRESS
4308 Suitland Rd., Suitland, Md. | | 25a. DATE REC'D. BY REGISTRAR
AUG 27 1979 | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE
<i>Harvey McCreedy</i> | | | | |

BP

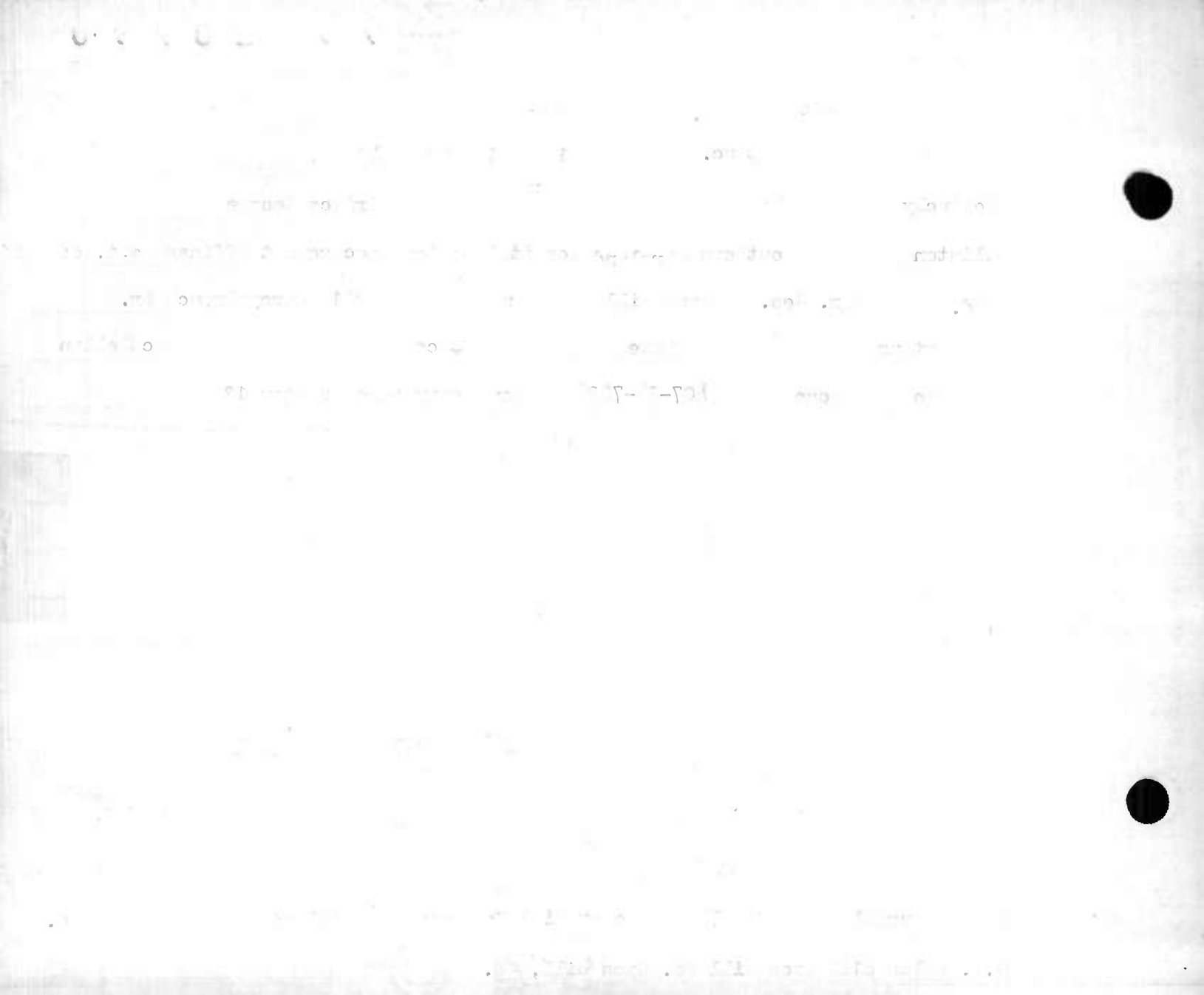
WASHINGTON D. C. 20540
8108 OLD SHAKER HILL RD. S.E.
BENJAMIN S. PERSON M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | 9 20790 | |
|--|--|-----------------------------|--|---|-----------------------------------|--|-------------------------------------|--|---|--|--|
| 1- FOR STATE REGISTRAR | | | REG. NO. | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a DATE OF DEATH MONTH DAY YEAR | | | 2b HOUR | | |
| Bonnie R. Perry | | | | | | 8 23 79 | | | 2.45 PM | | |
| 3. SEX | | 4 RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6 AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR IF UNDER 24 HRS | |
| Female | | Cauc. | | 10 1 29 | | | 49 | | | MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Kentucky | | USA | | | | | Prince George MD. | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Clinton | | | Southern Maryland Hospital Center | | | Procurement Officer Dept. of Agri | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET ADDRESS | | | |
| Md. | | Pr. Geo. | | Oxon Hill | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 8017 Carey Branch Dr. | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| Arthur Rowe | | | | Grace McClellan | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17 INFORMANT ADDRESS | | | | | |
| no | | | | none | | 407-34-7238 Harry Perry same as item 13 | | | | | |
| 11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Respiratory arrest.</u> | | | | | | | | | | 4 days | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Intracerebral Hemorrhage</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Possible Berry Aneurysm</u> | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? | | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | |
| | | | P.M. 19 | | | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>8. 20</u> 19 <u>79</u> to <u>8. 23</u> 19 <u>79</u> that (I) (we) last saw the deceased alive on <u>8. 22</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| <u>Seta Sultanian</u> | | | | | | | | | 8. 23. 79 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e ADDRESS | | | | | |
| SETA SULTANIAN | | | | | | 6188 Oxon Hill Rd Oxon Hill Md 20021 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | | 8/25/79 | | Cedar Hill Cemetery | | | Suitland Md. | | | |
| 24 FUNERAL DIRECTOR NAME ADDRESS | | | | | | 25a DATE REC'D. BY REGISTRAR | | | 25b REGISTRAR'S SIGNATURE | | |
| G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md. | | | | | | AUG 27 1979 | | | <u>[Signature]</u> | | |





DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 20791
REG. NO. | | | | | |
|--|--|-------------------------|--|--|--|---|---|---|---------------------------|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Bertha A. PETTIT</i> | | | | | | | 2b. DATE KNOWN OF DEATH
ESTI. MATED <i>8-21 1979</i> | | 2b. HOUR
M <i>3:30</i> | | | | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR <i>5-9-97</i> | | 6. AGE (IN YEARS
(LAST BIRTHDAY) <i>82</i> YRS. | | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR <i>8-21 1979</i> | | 2d. HOUR
M <i>3:30</i> | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Wash., D.C.</i> | | | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Prince Georges</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Cheverly</i> | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Pr. Geo. Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Ret. Saleslady</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>-</i> | | | |
| 13a. STATE
<i>Md.</i> | | | | 13b. COUNTY
<i>Pr. Geo.</i> | | 13c. CITY OR TOWN
<i>Hyattsville</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
<i>630 - Sheridan St.</i> | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Walter A. Barkley</i> | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Elizabeth (Unknown)</i> | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
<i>No</i> | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>-</i> | | 17. INFORMANT
ADDRESS
<i>Mary E. Crumb (above address)</i> | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular disease</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>August P. Prady</i> | | | | TITLE (SPECIFY)
<i>M.D. Prady</i> | | | | MEDICAL EXAMINER
DATE SIGNED <i>8-21-79</i> | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
<i>August P. Prady</i> | | | | ADDRESS
<i>5009 Rayburn Crest, Camp Springs</i> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | | | 23b. DATE
<i>8/27/1979</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Cedar Hill Cem.</i> | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Suitland Pr. Geo. Md.</i> | | | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>Nalley's F.H. Inc.</i> | | | | ADDRESS
<i>Mt. Rainier, Md.</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>AUG 27 1979</i> | | | | 25b. REGISTRAR'S SIGNATURE
<i>Anthony McBrady</i> | | | |

5201 BP

DHMM - 17
(V.R. 115 ME (1))
15M 7/76

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH20792
REG. NO.1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|---|-------------------------|--|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Fannie L. PHILIPS | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
8-21 1979 | | | 2b. HOUR
3:30 PM | | |
| 3. SEX
Female | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
6-9-02 | 6. AGE (IN YEARS)
MONTHS DAYS
77 | IF UNDER 1 YR.
MONTHS DAYS
77 | IF UNDER 24 HRS.
HOURS MIN.
77 | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
8-21 1979 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Georgia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince Georges | | |
| 10. CITY OR TOWN OF DEATH
Mt, Ranier | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Prince George General | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
None |
| 13a. STATE
Pa. | | | 13b. COUNTY
Unknown | 13c. CITY OR TOWN
Norristown | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
701 Violet St | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Huff | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ruby Griffin | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
None | | 17. INFORMANT
ADDRESS
Bklyn, N.Y.
Minnie Stanley (Daughter) | | | |
| 18. CAUSE OF DEATH (Enter only one cause prevailing for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Cordis vascular disease
4029
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE
August P. Rodriguez | | | TITLE (SPECIFY)
M.D. | | | DATE SIGNED
8-21-79 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
August P. Rodriguez | | | ADDRESS
5009 Rayburn Court Camp Springs Md 20746 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
8/25/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Landover, PGC, Maryland | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Modern Funeral Home 3821-14th St, N.W. Wash, D.C. | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 29 1979 | | 25b. REGISTRAR'S SIGNATURE
Patrick McCready | | |

MEDICAL CERTIFICATION

BP

DHMH: 17
(VR A15 ME (5))
15M 7/76

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

11272

2015 12 15 14:34

Results

24

JN 384724 101

Emory Griffin

• • •

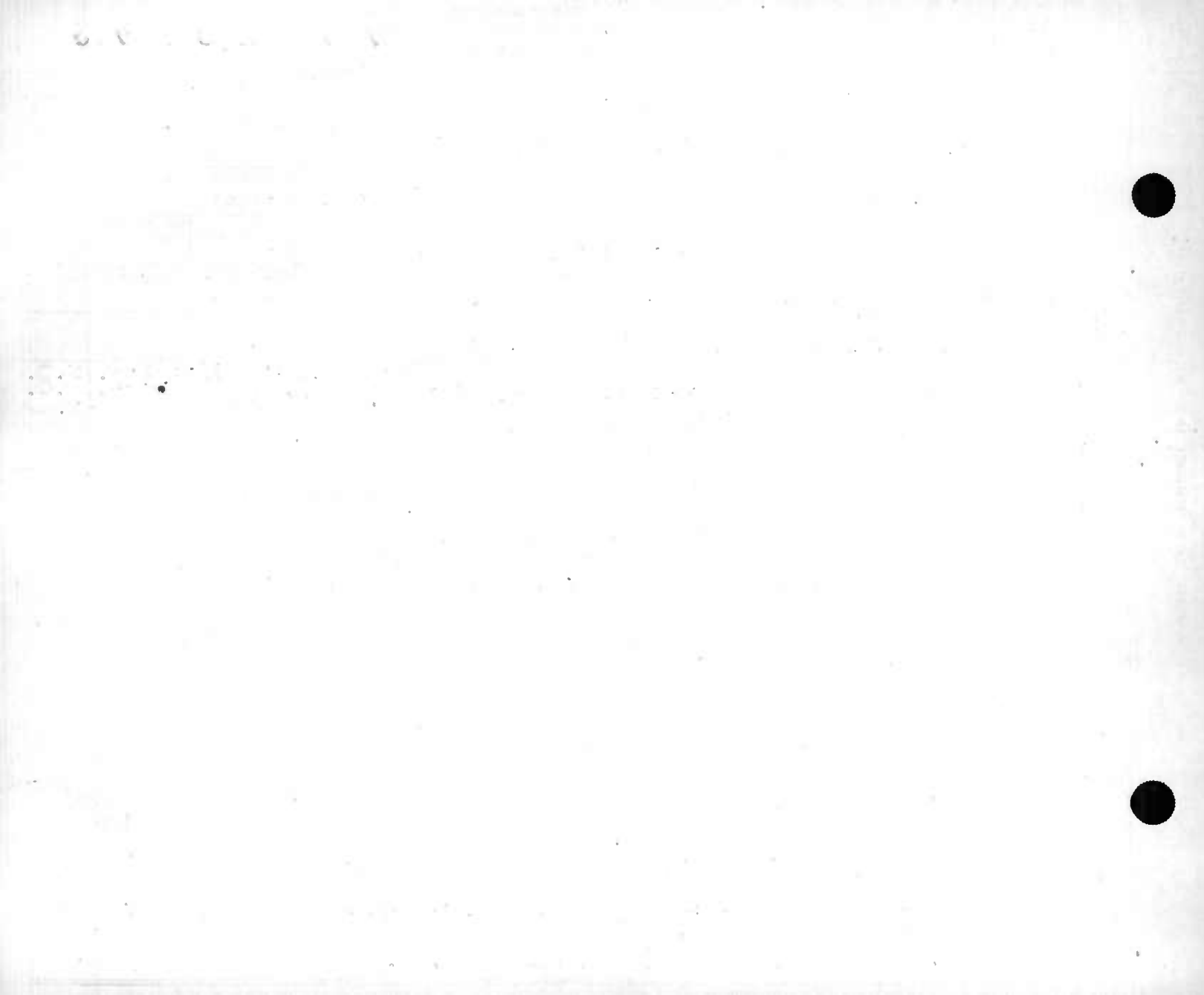
357-14th St. N.W. Wash. D.C.
The Modern Tower Hotel
Suite 525/9 Lincoln

TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|---|---|--|---|--|
| 1 - FOR STATE REGISTRAR | | REG. NO. | | 9 20793 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
LYDIA PHILLIPS | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
08 21 79 | | | 7b. HOUR
5:05A.M. | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
07 18 89 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 | | IF UNDER 1 YEAR
MONTHS DAYS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince Georges County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Southern Maryland Hospital Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
None | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Md. Pr. Georges Clinton | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
American Nursing Home
Stuart Lane | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Jones | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Annie Smith | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
578-36-1755 | | 17. INFORMANT
1322 North Carolina Ave., N.E.
Ms. Lillie Pratt-niece- Wash., D.C. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>
5789
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Possible Acute myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiovascular bleeding</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>sudden</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>Renal failure - Probable Melanoma</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/20</u> , 19 <u>79</u> , to <u>8/21</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>8/20</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>R. M. ...</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>R. M. ...</u> | | | | 22e. ADDRESS
<u>4235 25th Ave. N.E. 20031</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
<u>8/25/79</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Lincoln Memorial Cemetery</u> | | 23d. LOCATION
<u>Suitland, Maryland</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Stewart Funeral Home-4001 Benning Road, NE.</u> | | | | 25a. DATE REC'D. BY REGISTRAR
<u>AUG 27 1979</u> | | | | | |



MEDICAL EXAMINER NOTIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 2 0 7 9 4

REG. NO.

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Edward H. Pierce | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Aug. 29, 1979 | | 2b. HOUR
9:38 AM |
| 3. SEX
M | 4. RACE
B | 5. DATE OF BIRTH
MONTH DAY YEAR
1-6-1894 | 6. AGE (IN YEARS LAST BIRTHDAY)
85 | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince George's MD. | | |
| 10. CITY OR TOWN OF DEATH
Cheverly | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Prince George Gen. Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't. | |
| 13a. STATE
Md. | | | 13b. COUNTY
P.G. | 13c. CITY OR TOWN
Seabrook | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Franklin Pierce | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Addie Stard | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
CWW1 216-44-3286 | 17. INFORMANT
ADDRESS
Bessie Johnson-Same as # 13 above | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) MUELOPROLIFERATIVE DISEASE
2387 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 mos. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
ART. HEART DISEASE, CONGT. HEART FAILURE | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-8-79, 19, to 8-29-79, 19, that (I) (we) last saw the deceased alive on 8-23-79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Andres C. Lara | | | | 22c. DATE SIGNED
8-30-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ANDRES C. LARA, M.D., P.A. | | | | 22e. ADDRESS
9326 LANHAM - SEVERN ROAD | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
9-1-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Harmony Mem. Cem. | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Highland Park, Md. | | 24. FUNERAL DIRECTOR
NAME ADDRESS
H. S. WASHINGTON & SONS 4925 BURROUGHS AVE N.E. | | | |
| 25a. DATE REC'D. BY REGISTRAR
SEP 10 1979 | | | | 25b. REGISTRAR'S SIGNATURE
J. H. McCreedy | |

REPORT SUMMER 1962



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M/7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20795

| | | | | | |
|---|--|---|-------------------|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| POLESKY, Jr | | 8-7-79 | | A | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. |
| Male | White | 10-12-34 | 44 YRS. | | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 9b. CITIZEN OF WHAT COUNTRY? | 9c. DATE PRONOUNCED DEAD | | 9d. CITY OR COUNTY OF DEATH | |
| New York | USA | 8-7-79 | | Anne George | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Andrews | Andrews A.F.B. Hospital | Construction Work | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Md. | Anne Arundel | Annapolis | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| Peter | Polesky, Sr. | Bertha | | Cook | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| Yes | 082-30-7288 | Mary A. Polesky, 4513 Rena Rd. | | Forestville, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Arterio sclerotic Cardiovascular disease | | | | | |
| 4292 | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> | | | | STREET CITY OR TOWN COUNTY STATE | |
| AT WORK <input type="checkbox"/> | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| Augusto P. Rodriguez | | Deputy | | 8-7-79 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | |
| Augusto P. Rodriguez, M.D. | | 5009 Rayburn Ct., Camp Springs, Md. 20031 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 8-10-79 | | Wash. Natl. Cem. | |
| 24. FUNERAL DIRECTOR NAME | | 24b. ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | |
| Robt E Wilhelm | | 4308 Suitland Rd., Suitland, Md. | | AUG 14 1979 | |
| 25b. REGISTRAR'S SIGNATURE | | 25c. REGISTRAR'S SIGNATURE | | | |
| | | | | | |

2010 10-10-10

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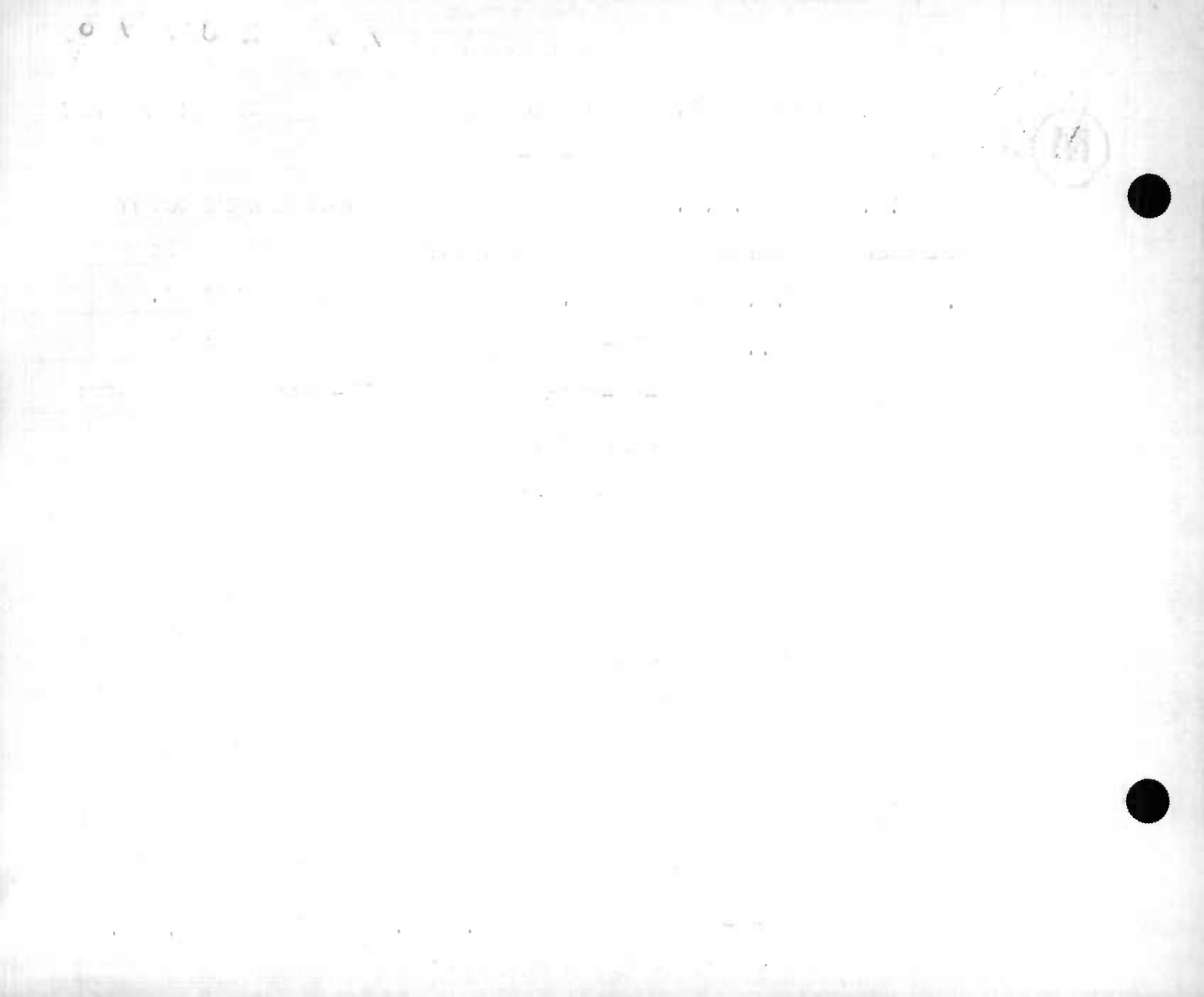
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|---|---|------------------------------------|--|---|---|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | |
| REG. NO. | | | | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| AUDREY L. POWELL | | | | | | 08 01 79 | | 7:05 PM | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR IF UNDER 24 HRS | |
| F | | B | | 5-21-1916 | | 63 YRS | | MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| D.C. | | U.S.A. | | | | PRINCE GEORGE'S COUNTY MD. | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| CHEVERLY | | PRINCE GEORGE'S GENERAL HOSPITAL | | | | Housewife | | Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13a CITY OR TOWN | | | 13b INSIDE CITY LIMITS? | | 13c STREET ADDRESS | |
| 13a STATE | | | 13b COUNTY | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5011 Sheriff Rd. | |
| Md. | | | P.G. | | | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | |
| John M. Wallace | | | Annie Queen | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b SOCIAL SECURITY NO. | | | 17 INFORMANT ADDRESS | | | |
| No | | | 579-16-1205 | | | Samuel Powell-Same as # 13 above | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EDEMA
4140
DUE TO, OR AS A CONSEQUENCE OF
(b) Atherosclerotic Heart disease
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | | | P.M. 19 | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | CITY OR TOWN COUNTY STATE | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/1, 1979, to 8/1, 1979, that (I) (we) lost saw the deceased alive on 8/1, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| Dusan Lajda | | | MD | | | | | 8/2/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | |
| DUSAN LAJDA, MD | | | 6201 greenbelt Rd., College Pk., Md | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | |
| Burial | | | 8-4-79 | | Harmony Mem. Cem. | | Highland Park, Md | | |
| 24 FUNERAL DIRECTOR NAME | | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| H.S. Washington & Sons | | | 4925 N.H. Ave | | AUGO 7 1979 | | D. J. McCreedy | | |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH20797
REG. NO.1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|-------------------------|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Gail M. Smith Price | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 8-21 1979 | | | 2b. HOUR
M 1550 | | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR 11-6-55 | | 6. AGE (IN YEARS)
LAST BIRTHDAY 23 YRS. | | 7c. DATE PRONOUNCED
DEAD 8-21 79 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington D.C. | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. CITY OR COUNTY OF DEATH
Prince Georges MD. | |
| 10. CITY OR TOWN OF DEATH
Cheverly | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Prince George General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Sergeant | | | 12b. KIND OF BUSINESS
U.S. Air Force | |
| 13a. STATE
Maryland | | | 13b. COUNTY
Prince George | | 13c. CITY OR TOWN
Lanham | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
10301 Lanham Severn Road | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Herbert C. Smith | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Florence M. Gantt | | | 16a. SOCIAL SECURITY NO.
217 66 0724 | | | 17. INFORMANT
Florence M. Smith | |
| 16b. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | | 16c. RETIRED
Retired | | | 17a. ADDRESS
6731 New Hampshire Ave. Takoma Park, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot wound of the head
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
9:10 P.M. 8-21 1979 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject shot herself, not while at work. | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
At Home | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
1331 Lanham Severn Rd., Seabrook, PG, Md. | | | | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE
August P. Rodriguez | | | TITLE (SPECIFY)
M.D. | | | MEDICAL EXAMINER
August P. Rodriguez | | | DATE SIGNED
8-22-79 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
August P. Rodriguez | | | ADDRESS
5009 Regburn Court, Camp Springs Md 20746 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
8/28/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cem | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington Arlington Va. | | |
| 24. FUNERAL DIRECTOR
Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 27 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

9902

2004

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20798
REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | | | |
|---|--|------------------|--|--|--|--|--|--|--|-------------------------------|--|---|--|--|--|---|--|------------|--|---------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Thomas | | MIDDLE
T. | | LAST
PROCTOR | | 2a. DATE KNOWN
OF DEATH
ESTIMATED | | MONTH
8-28 | | DAY
19 | | YEAR
79 | | 2b. HOUR
M | | | | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
6-10-22 | | 6. AGE (IN YEARS)
LAST (IN DAYS)
37 YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | 7c. DATE
PRONOUNCED
DEAD | | MONTH
8-28 | | DAY
19 | | YEAR
79 | | 2d. HOUR
M | |
| 7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Cheverly | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
Prince George General Hospital | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS
OR INDUSTRY | | | | | |
| 13a. STATE
Md. | | | | 13b. COUNTY
P.G. Co. | | | | 13c. CITY OR TOWN
Brandywine | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET ADDRESS
10700 Cedarville Rd. | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James G. Proctor | | | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Cora Swann | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
WW # 2 | | | | 17. INFORMANT
Rose Vermetta Proctor SAA | | | | ADDRESS | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular disease</u>
4292
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE
August P. Rodriguez | | | | TITLE (SPECIFY)
M.D. Deputy | | | | MEDICAL EXAMINER | | | | DATE
SIGNED 8-29-79 | | | | | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
August P. Rodriguez | | | | ADDRESS
5009 Rayburn Court, Camp Springs | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
8/31/1979 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Resurrection Cem. | | | | 23d. LOCATION
(CITY OR TOWN)
Clinton P.G. Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Martell Adams | | | | ADDRESS
Adams Funeral Home Aquasco Md | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 4 1979 | | | | 25b. REGISTRAR'S SIGNATURE
L. J. Halburty | | | | | | | | | |

MEDICAL CERTIFICATION

8 2 2 2

Two to four days

... ..

... ..

... ..

1938

...

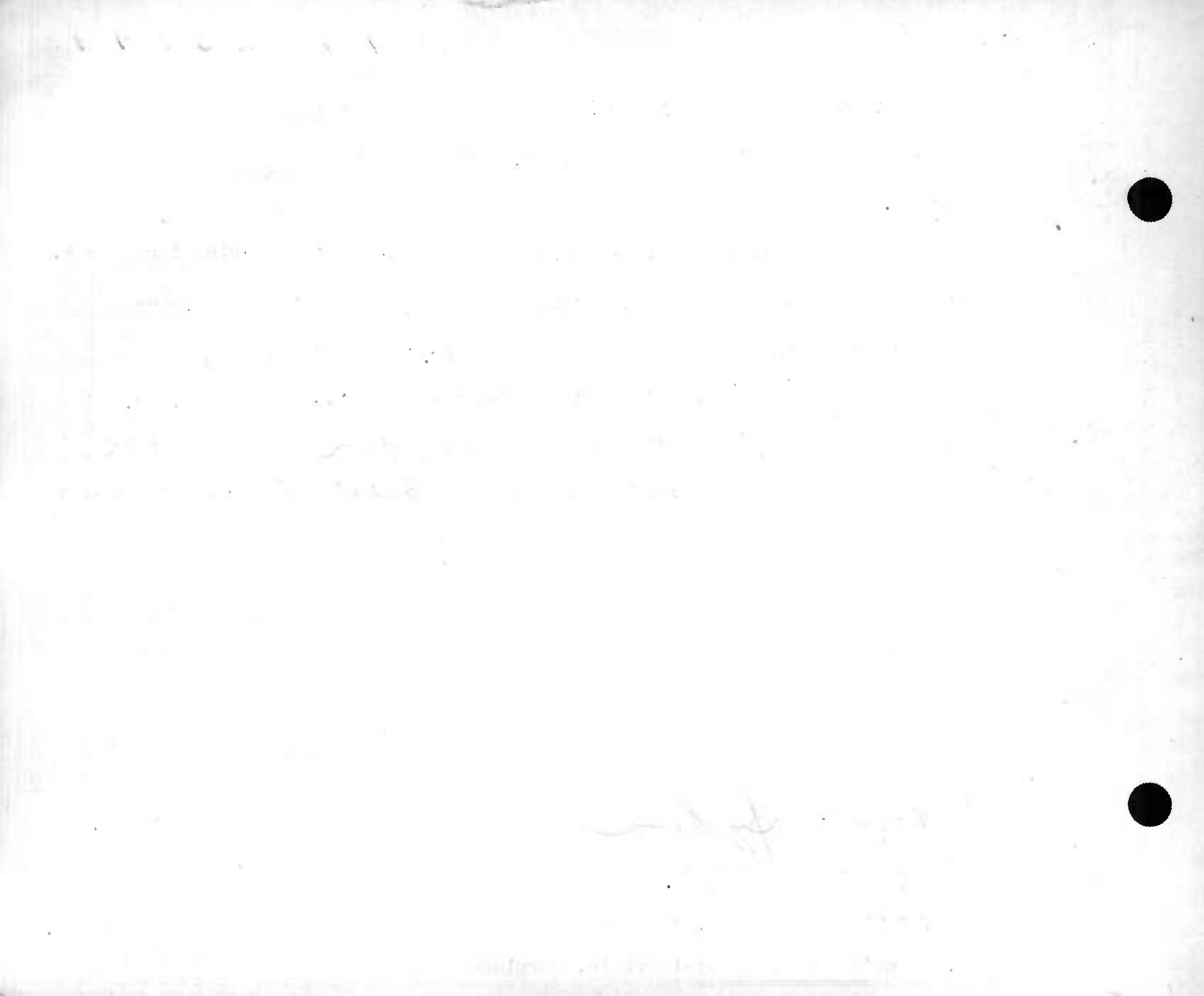
Released by Medical Examiner to PMD

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. 9 20799 | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| Charles Melvin | | Raley | | | | | | August 12, 1979 | | 12:15 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| male | | white | | Nov 27, 1919 | | 59 | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Washington D C | | U S A | | | | Prince George's MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Lanham | | Doctors' Hosp. of Prince Georges Co | | | | | | Retired | | Agriculture Dept. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | |
| Md | | Pro Georges | | New Carrollton | | | | 6628 Chestnut avenue | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| Robert Raley | | | | Gertrude Tinnett | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT ADDRESS | | | | | |
| no | | | | 579 12 0521 | | Alice H Raley New Carrollton, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) Myocardial infarction | | | | | | | | | | 1 HR | |
| 410- DUE TO, OR AS A CONSEQUENCE OF (b) ANTERIOGRAFTIC Heart Disease | | | | | | | | | | 2 years | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1978, 19, to 8/12/79, 19, that (I) (we) last saw the deceased alive on August 12, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | | | 22c. DATE SIGNED | | | |
| Roger Bowman Ingham, M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 8/13/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | |
| Roger Bowman Ingham, M.D. | | 5701 - 85th Ave., New Carrollton, Md. 20784 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | Aug 15, 1979 | | Ft Lincoln Cemetery | | Brentwood Pro Georges Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| F. Gasch's Sons P A | | Hyattsville, Maryland | | AUG 16 1979 | | F. Gasch's Sons P A | | | | | |



Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 20800

| | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Phyllis E. Ranier | | | 2a. DATE OF DEATH
MONTH DAY YEAR
Aug 08 1979 | | | 2b. HOUR
1:30A M | | | |
| 3 SEX
F | | 4 RACE
White | | 5 DATE OF BIRTH
MONTH DAY YEAR
April 3, 1926 | | 6 AGE (IN YEARS LAST BIRTHDAY)
53 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince George County MD | | | |
| 10 CITY OR TOWN OF DEATH
Laurel | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Greater Laurel Beltsville Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY
Hospital | |
| 13a. STATE
Md | | | 13b. COUNTY
P. G. | | 13c. CITY OR TOWN
Laurel | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Louis F. Ranier | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Myrtle P. Werkheiser | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES
no | | | |
| 16b. SOCIAL SECURITY NO.
178 22 0217 | | | 17. INFORMANT
ADDRESS
Elva Ranier same as above | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u>
1830
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ovarian carcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 1/2 years</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 minutes | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/14</u> , 19 <u>79</u> , to <u>8/8</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>8/8</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Stuart E. Selonick, M.D. | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
8/8/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stuart E. Selonick, M.D. | | | 22e. ADDRESS
Greater Laurel Hospital, Laurel Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
August 11, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Denison Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Swoyersville Harford County | | |
| 24. FUNERAL DIRECTOR
NAME
J.H. | | | ADDRESS
Laurel, Md | | | 25. DATE RECEIVED BY REGISTRAR
AUG 10 1979 REGISTRAR'S SIGNATURE | | | |

50802

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH REGULAR AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH20801
REG. NO.

| | | | | | |
|---|-------------------------|--|---|---|------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) AKA Albert Carroll Rawlings | | 7a. DATE KNOWN OF DEATH
ESTIMATED 8-23 1979 | | 7b. HOUR 11:24 | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR 11-10-21 | 6. AGE (IN YEARS)
LAST BIRTHDAY 57 YRS. | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash. D.C. | | 8. CITIZEN OF WHAT COUNTRY?
USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince Georges | |
| 10. CITY OR TOWN OF DEATH
Forestville | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
9524 ACORN PARK ST. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED | |
| 12b. KIND OF BUSINESS OR INDUSTRY
PAINTER | | 13a. STREET ADDRESS
9524 ACORN PARK ST. | | 13b. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ALBERT C. RAWLINGS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
VERGIE F. PAXSON | | 16. SOCIAL SECURITY NO.
218-34-5643 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NBS | | 16b. SOCIAL SECURITY NO.
218-34-5643 | | 17. INFORMANT
ADDRESS
HELEN RAWLINGS SAME AS #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1629 Bronchogenic carcinoma
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
(c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE
Augusto P. Rodriguez | | TITLE (SPECIFY)
Deputy | | DATE SIGNED
8-23-79 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Augusto P. Rodriguez | | ADDRESS
5009 Rawlins Court, Prince Georges | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
8-27-79 | | 23c. NAME OF CEMETERY OR CREMATORY
MD VETERAN CEM. | |
| 23d. LOCATION
CITY OR TOWN
CHELTENHAM | | 23e. DATE REC'D. BY REGISTRAR
AUG 27 1979 | | 23f. REGISTRAR'S SIGNATURE
Anthony M. Brady | |
| 24. FUNERAL DIRECTOR
NAME
G.F. KALAS | | ADDRESS
6160 OXON HILL RD. | | 25a. DATE REC'D. BY REGISTRAR
AUG 27 1979 | |

1000000000

number of flowers per tree

100

5

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND | | | | | | | | | | 20802 | |
|---|--|-------------------------|--|--|--|---|--|---|--|--|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | REG. NO. | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Holen Juanita RAWLS</i> | | | | | | | | | | 2a. DATE KNOWN OF DEATH
MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <i>8-24 1979</i> | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>Black</i> | | 5. DATE OF BIRTH
MONTH <i>12</i> DAY <i>3</i> YEAR <i>49</i> | | 6. AGE (IN YEARS)
MONTHS <i>29</i> YRS. | | IF UNDER 1 YR.
MONTHS <i></i> DAYS <i></i> | | IF UNDER 24 HRS.
HOURS <i></i> MIN. <i></i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>N.C.</i> | | | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Home Georges</i> | |
| 10. CITY OR TOWN OF DEATH
<i>Cheverly</i> | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Prince Georges General Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE <i>District of Columbia</i> | | | | | | | | | | | |
| 13b. CITY OR TOWN <i>Washington</i> | | | | | | | | | | | |
| 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 13d. STREET ADDRESS <i>2603 Douglas Rd., S. E.</i> | | | | | | | | | | | |
| 14. FATHER'S NAME
FIRST <i>John</i> MIDDLE <i>L.</i> LAST <i>Moody</i> | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST <i>Clementine</i> MIDDLE <i></i> LAST <i>Turner</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) <i>NO</i> | | | | | | 16b. SOCIAL SECURITY NO. <i>577-68-0488</i> | | | | | |
| 17. INFORMANT <i>Mrs. Ella Pickett-Sister-In-Law</i> | | | | | | ADDRESS <i>500-69th Street, Seat Pleasant MD</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
<i>Metastatic endometrial adenocarcinoma of the ovary</i>
<i>1830</i>
IMMEDIATE CAUSE (a) <i></i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i></i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i></i> | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | |
| 19c. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 20b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21a. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21c. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> | | | | | | TITLE (SPECIFY) <i>M.D. Deputy</i> | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez</i> | | | | | | MEDICAL EXAMINER ADDRESS <i>5009 Rayburn Court, Camp Springs, Md 20747</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | | | 23b. DATE <i>9/1/79</i> | | | | 23c. NAME OF CEMETERY OR CREMATORY <i>Church Cemetery Cool Spring Baptist</i> | | | |
| 23d. LOCATION CITY OR TOWN <i>Gaston</i> | | | | 23e. COUNTY <i>North Carolina</i> | | | | 23f. STATE | | | |
| 24. FUNERAL DIRECTOR NAME <i>Stewart Funeral Home-4001 Benning Rd., N.E.</i> | | | | | | 25a. DATE REC'D. BY REGISTRAR <i>AUG 31 1979</i> | | | | | |
| 25b. REGISTRAR'S SIGNATURE <i>Pickney McCready</i> | | | | | | | | | | | |

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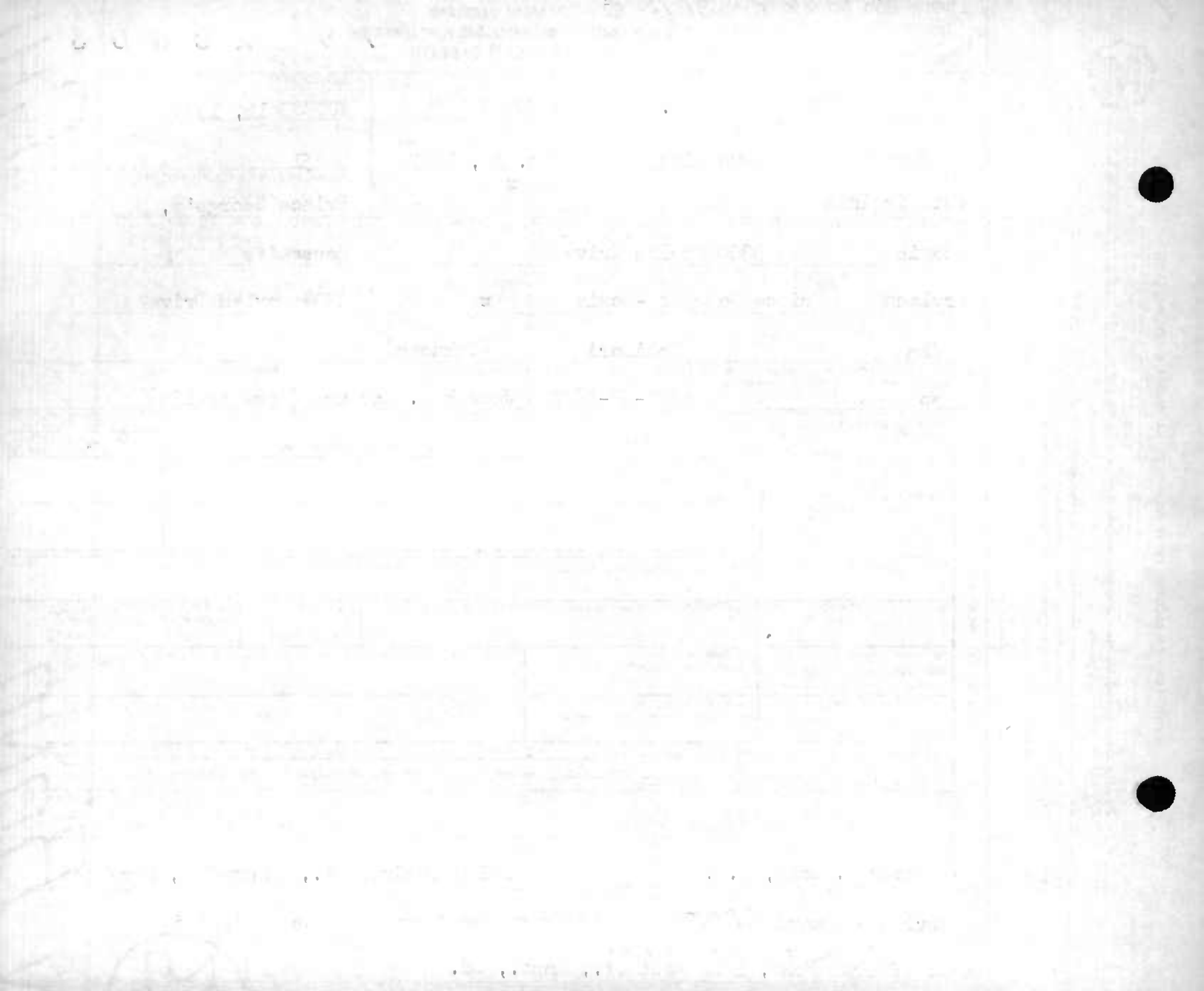
1959

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|---|--|--|---|--|
| 1- FOR STATE REGISTRAR
20803
REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
EDITH P. RAYBURN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
AUGUST 16, 1979 | | | 2b. HOUR
AM | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
Dec. 17, 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY)
51 YRS. | | IF UNDER 1 YEAR
IF UNDER 24 HRS
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince George's, MD | | | |
| 10. CITY OR TOWN OF DEATH
Bowie | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3304 Moylan Drive | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland | | | | | 13b. COUNTY Prince Georges | | 13c. CITY OR TOWN | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Jim Polinori | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
(Unknown) | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
232-52-5622 | | 17. INFORMANT ADDRESS
Joseph W. Rayburn (same as 13c) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic Hypernephroma</u>
1890
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/8</u> 19 <u>78</u> to <u>8/16</u> 19 <u>79</u> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Enser W. Cole</u> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
8/16/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Enser W. Cole, M.D. | | | | 22e. ADDRESS
121 Cathedral St., Annapolis, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial - Removal | | 23b. DATE
8/20/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodmere Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
West Virginia | | | |
| 24. FUNERAL DIRECTOR NAME
Beall Funeral Home, 1212 West St., Anna., Md. | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 17 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>Jeffrey McCreedy</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|--|--|---|---|---|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | 7 9 2 0 8 0 4
REG. NO. | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
JOHN S REAVES | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
08 24 79
2b. HOUR
8:00A.M. | | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
OCT. 14, 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY)
58
YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NORTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGES MD. | | | | |
| 10. CITY OR TOWN OF DEATH
CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PRINCE GEORGES GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired Police Officer
12b. INDUSTRY
Metropolitan Police | | | | |
| 13a. STATE
Maryland | | | | | 13b. COUNTY
Prince Geo. | | 13c. CITY OR TOWN
Hyattsville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
JOHN G. REAVES | | | | | 15. MOTHER'S MAIDEN NAME
MARY FRANCES PRINCE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II | | 17. INFORMANT ADDRESS
Dorothy C. Reaves Same as #13 | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) <u>Ruptured Abdominal Aneurysm</u>
4413
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
14 hours | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Peptic Ulcer</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8-23-79</u> to <u>8-24-79</u> , that (I) (we) lost saw the deceased alive on <u>8-24-79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>V.P. Singh</u> | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
V. P. SINGH M.D. | | 22e. ADDRESS
3700 E.W. Hwy. #100
Hyattsville Md. 20782 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
8/28/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood P.G. Md. | | | | |
| 24. FUNERAL DIRECTOR
Francis Gasch's Sons Funeral Home, P.A.
Hyattsville, Maryland | | | | | 25. DATE REC'D. BY REGISTRAR
AUG 28 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>Dorothy C. Reaves</u> | | | |

BP

20805

1 - FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|---------------------|--|-------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | REG. NO. | | 3a. TIME OF DEATH | |
| CHARLES | | E. | | | | REYNOLDS | | 8 15 79 | | | | 8:20P M | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| Male | | Caucasian | | Jan. 17, 1939 | | 40 YRS | | MONTHS | | DAYS | | HOURS MIN | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Washington D.C. | | US.A. | | | | Prince Georges | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| RIVERDALE | | EUGENE LELAND MEMORIAL HOSPITAL | | Shop Manager | | Automobile | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET ADDRESS | | | |
| Maryland | | P.G. | | Marlow Hghts. | | | | | | 2723 Keating Street | | | |
| 14 FATHER'S NAME | | MIDDLE | | LAST | | 15 MOTHER'S MAIDEN NAME | | FIRST | | MIDDLE | | LAST | |
| Charles | | S. | | Reynolds | | Amelia | | E. | | | | Pertino | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| Yes | | Vietnam | | 577-50-8275 | | Jean Shelton | | 2350 Plum Pt. Rd. | | Huntington, Md. | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF (b) | | DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 5715 | | Septic Shock | | massive GI bleeding | | Cirrhosis of the Liver | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 8/7/79 | | massive GI bleeding | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/3/79, 1979, to 8/15/79, 1979, that (I) (we) last saw the deceased alive on 8/15, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) and (I) (do not) view the body after death. | | 22b. SIGNATURE | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 17. DATE SIGNED | | | | | |
| | | ABRAHAM DABELA M.D. | | | | | | 8/16/79 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS | | | | | | | | | | | |
| ABRAHAM DABELA M.D. | | Queensbury Rd Rutherford, Md. | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| Burial | | Aug. 18, 1979 | | Cedar Hill Cem. | | Suitland P.G. Md. | | | | | | | |
| 24 FUNERAL DIRECTOR NAME | | 24b ADDRESS | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | | | | | |
| Lee Funeral Home, Inc. | | 6633 Old Alexander Ferry Rd. Clinton, Md. | | AUG 24 1979 | | Dorothy McCurdy | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

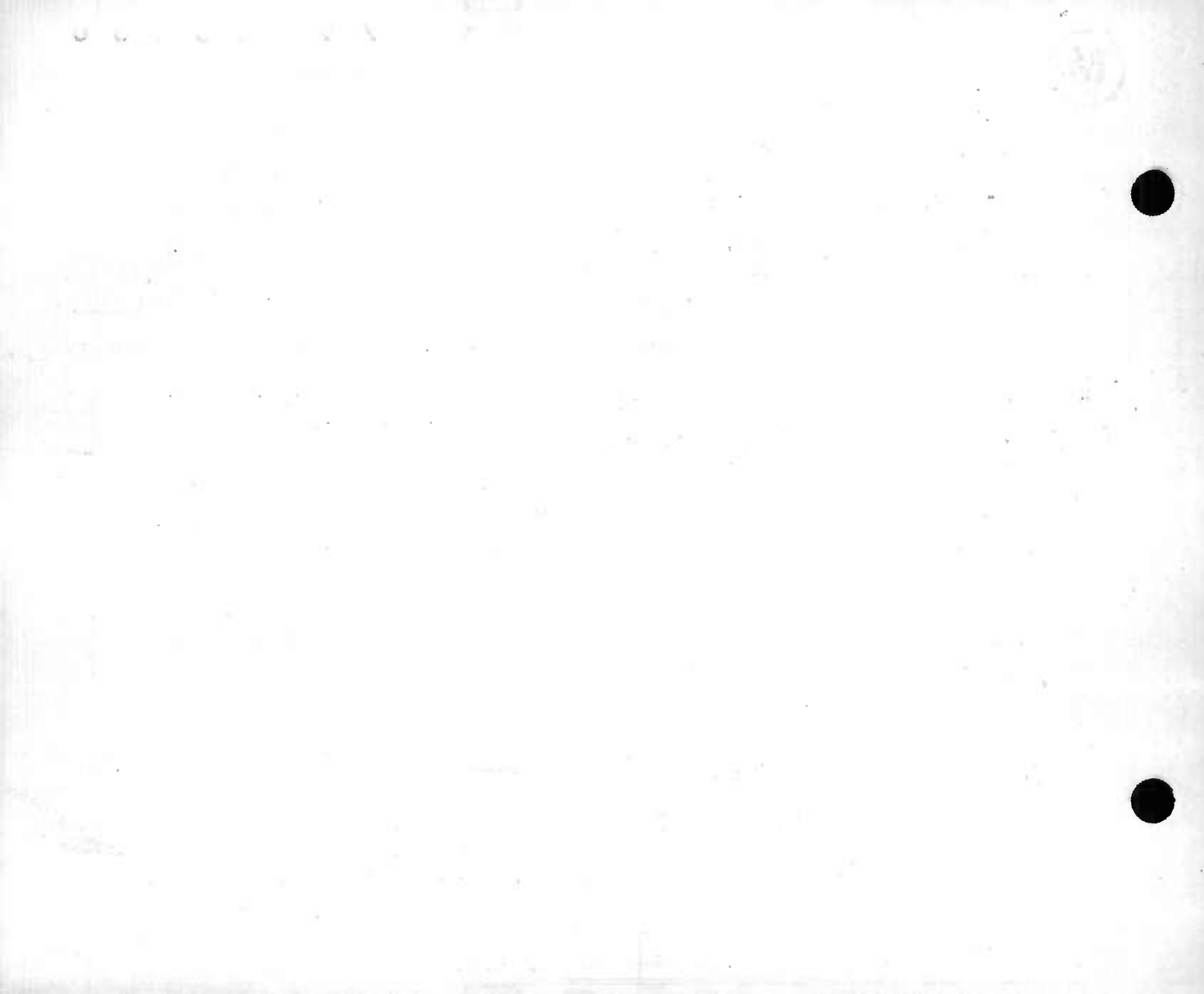
MEDICAL CERTIFICATION

TO HOSPITALS: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 7 9 2 0 8 0 6 | | | |
|--|--|---|--|--|--|---|--|-------------------------|--|--------------------|-----|--|----------|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1 DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a DATE OF DEATH | | MONTH | DAY | YEAR | 2b HOUR |
| Walter | | Rogers | | | | | | August 11, 1979 | | | | | 8:50a.M. |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| male | | Negro | | MONTH DAY YEAR
Jul 18 1940 | | 39 YRS. | | MONTHS DAYS | | HOURS MIN. | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| N. C. | | USA | | | | Prince George's County MD. | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Lanham | | Doctors' Hosp. of Prince Geo.'s Co. | | Security Officer | | None | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET ADDRESS | | | |
| Maryland | | PG | | New Carrollton | | NO <input type="checkbox"/> | | 7611 Fountainbleu Drive | | | | | |
| 14 FATHER'S NAME | | 15 MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| FIRST MIDDLE LAST
Walter S. Rogers | | FIRST MIDDLE LAST
Rosalie Lee Moorehead | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | | | | | | | | | |
| No | | 243-54-6146 | | Mrs. Frances Rogers/wife/1903 23rd | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Electro mechanical Dissociation 10 days</u>
410-
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Acute Myocardial Infarction 1 1/2 hours</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Recent MI, Coronary Artery Disease</u> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>Hypertension</u> | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. — 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>8/11/79</u> , 19 <u>79</u> , to <u>8/11/79</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>8/11/79</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b SIGNATURE | | DEGREE | | 22c DATE SIGNED | | | | | | | | | |
| <u>W. S. Rao</u> | | MD | | 8/11/79 | | | | | | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS | | | | | | | | | | | |
| <u>A. Hook S. Rao</u> | | <u>Doctors' Hospital - Lanham</u>
9131 Piscataway Rd., Clinton, Md. 20735 MD. | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | |
| BURIAL | | 8/16/79 | | Ft. Lincoln Cemetery | | Brentwood, Maryland | | | | | | | |
| 24 FUNERAL DIRECTOR | | ADDRESS | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | | | | | |
| <u>John T. Rhines Co.</u> | | <u>3015 12th St., N.E., D.C.</u> | | <u>AUG 20 1979</u> | | <u>[Signature]</u> | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

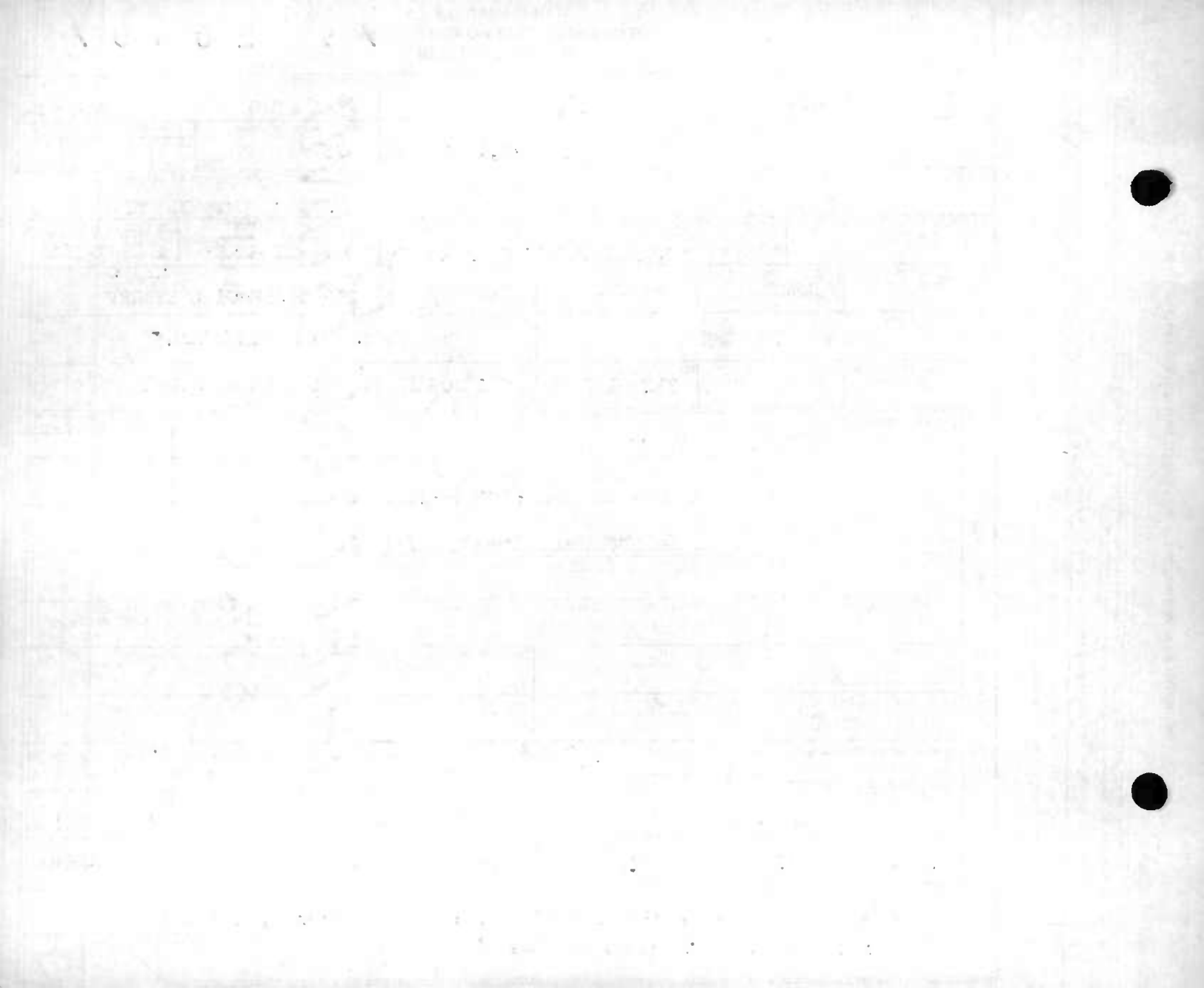
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|---|--|---|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. 9 20807 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
JOSEPH E. ROONEY | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
8.5.79 | | | | | 2b. HOUR
4:53 p.m. |
| 3. SEX M | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
SEPT 22, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGE COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
LAUREL | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
GREATER LAUREL BELTSVILLE HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CABINET MAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
INDUSTRIAL MFG CO | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY HOWARD 13c. CITY OR TOWN SAVAGE | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
212 COMMERCIAL STREET | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
JOSEPH A. ROONEY | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MARGARET ANNIE WHEELER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) 213 01 7692 | | 17. INFORMANT ADDRESS
MRS JOSEPH ROONEY SAME AS ABOVE | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a). <u>ASYSTOLE</u>
DUE TO, OR AS A CONSEQUENCE OF
(b). <u>CARDIOGENIC SHOCK</u>
DUE TO, OR AS A CONSEQUENCE OF
(c). <u>ISCHEMIC CARDIOMYOPATHY</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>8.4.79</u> to <u>8.5.79</u> , that (I) (we) lost
saw the deceased alive on <u>8.5.79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Christine De Lima</u> | | | | DEGREE
MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
8.5.79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CHRISTINE DE LIMA MD | | | | 22e. ADDRESS
3450 FT MEADE RD, LAUREL MD 20810 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
AUG. 8, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
SAVAGE CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SAVAGE, MARYLAND | | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
DONALDSON FUNERAL HOME, LAUREL, MD | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 15 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>notary m. Brady</u> | | | | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

9 20808

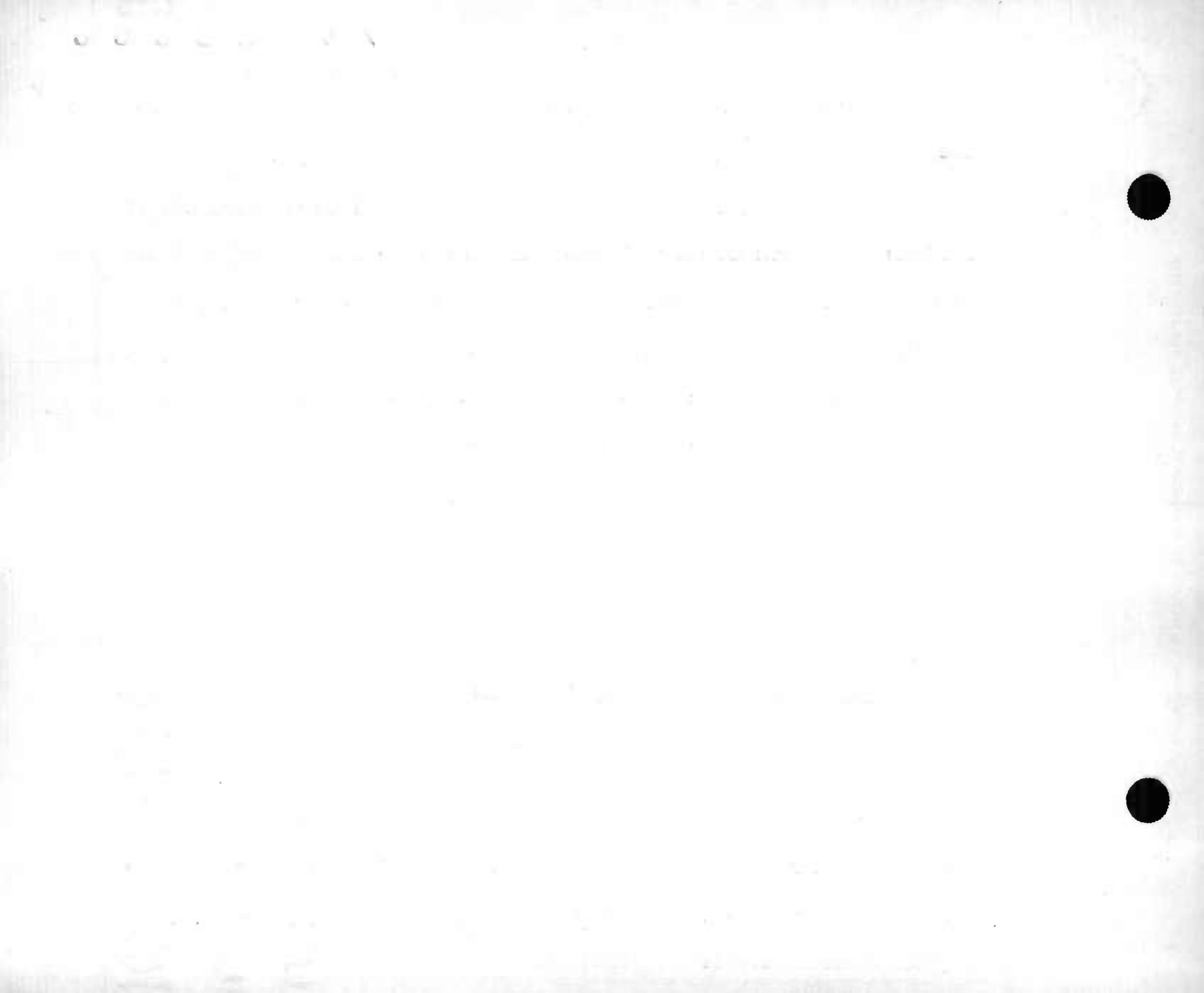
1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|---|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
PAUL B ROTHGEB | | | 2a. DATE OF DEATH
MONTH DAY YEAR
08 03 79 | | | 2b. HOUR
9:45
M | | | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 27, 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
62
YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
00 00 | | 7. IF UNDER 24 HRS
HOURS MIN.
00 00 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGE'S COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PRINCE GEORGE'S GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
General Manager | | | 12b. KIND OF BUSINESS OR INDUSTRY
Uline Arena | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
P.G.'s | | 13c. CITY OR TOWN
Bowie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
2903 Blueberry Lane | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Eliza Rothgeb | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bessie W. Maynard | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
WW II 220-10-5450 | | 17. INFORMANT
ADDRESS
Dorothy Rothgeb/Wife Same as 13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Heart Disease
4146
DUE TO, OR AS A CONSEQUENCE OF
(b) Cardiac failure
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 years
1 year | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug 3 1979 to Aug 3 1979 , that (I) (we) last saw the deceased alive on Aug 3 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22a. SIGNATURE
Nelson Goodman | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
8/4/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Nelson Goodman | | | | | | 22e. ADDRESS
3231 Superior Lane, Bowie, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | | 23b. DATE
Aug 5 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
George Washington Medical School | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | | | |
| 24. FUNERAL DIRECTOR
NAME
Capitol Funeral Service | | | | | | ADDRESS
Fairfax, Va. | | | 25. DATA RECEIVED BY REGISTRAR
AUG 8 1979 | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|--|---|---|---|
| 1. FOR
STATE
REGISTRAR | | | | | 7 9 2 0 8 0 9
REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Alvise E. Rowland</i> | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 8 10 79 | | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>Black</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>11-27-1895</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>83</i> YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Virginia</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Prince George</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Largo</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Manor Care Nursing Home</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Restaurant worker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Food</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE <i>Virginia</i> 13b. COUNTY <i>Lexington</i> | | | | | 13c. CITY OR TOWN
<i>Lexington</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Isaac Rowland</i> | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Janie Day</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>Yes.</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>WW II</i> | | 17. INFORMANT
<i>Dr. Isaac H. Rowland (son)</i> | | ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY.
<i>1889</i>
IMMEDIATE CAUSE (a) <i>Metastatic carcinoma</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Carcinoma of the bladder</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>Oct 5 1978</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED.
<i>Prostatic enlargement & Ca bladder</i> | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) <i>Wendy P. Jones</i> attended the deceased from <i>Dec 15</i> 19 <i>78</i> to <i>Aug 10</i> 19 <i>79</i> , that (I) <i>(see)</i> last saw the deceased alive on <i>August 3</i> 19 <i>79</i> , and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above; (I) <i>did not</i> view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>W.P. Jones MD</i> | | | | | DEGREE | | 22c. DATE SIGNED
<i>8/10/79</i> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Wendy P. Jones-Key MD</i> | | | | | 22e. ADDRESS
<i>7601 Riverdale Rd, New Carrollton, MD</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>12 AUG '79</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Evergreen Cemetery</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Lexington, Virginia</i> | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>LEWIS FUNERAL HOME</i> | | ADDRESS
<i>112 N. Randolph Street, Lexington, VA.</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>AUG 14 1979</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Henry McCreedy</i> | | | |

LEWIS FUNERAL HOME, 112 N. Randolph Street, Lexington, VA.

Funeral 12 AUG '77 Evergreen Cemetery Lexington, Virginia

Yrs. WW II 230-01-0052 Dr. Isaac H. Rowland (son)

Isaac Rowland

Jane Day

Virginia

Lexington

212 Fuller St.

Largo

Manor Care Nursing Home

Restaurant worker

Virginia

USA

xx

Prince George

Female

Black

11-27-1895

83

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please mail this certificate to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 9 20810 | | | |
|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Charles Harvey Russell | | | | 2a. DATE OF DEATH MONTH DAY YEAR
Aug. 10 79 | | 2b. HOUR
8:00a M | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 19, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Prince George's MD. | |
| 10 CITY OR TOWN OF DEATH
Riverdale | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Eugene Leland Memorial | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ordinance | | 12b. KIND OF BUSINESS OR INDUSTRY
NOL | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE Maryland 13b COUNTY P.G. Co. 13c CITY OR TOWN Laurel | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1007 8th. Street | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
John T. Russell | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Cora E. Burriss | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No. | | 16b SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-05-4340A | | 17 INFORMANT ADDRESS
Gertrude T. Russell same as #13 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinomatosis</u>
<u>1539</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Carcinoma of colon</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
(c)
DUE TO, OR AS A CONSEQUENCE OF | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 months
6 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. certify that (I) (this hospital) attended the deceased from <u>Feb. 18, 19 72</u> to <u>Aug. 10 19 79</u> , that (I) (we) last saw the deceased alive on <u>Aug. 10 19 79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Carl J. Houmann</u> DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
8-10-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Carl J. Houmann, M.D. | | | | 22e. ADDRESS
4404 Queensbury Rd., Riverdale, Md. 20840 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
8/13/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie, Anne Arundel | |
| 24. FUNERAL DIRECTOR
FLECK LAUREL FUNERAL HOME, INC.
7601 Sandy Spring Rd. Laurel, Md. 20810 | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 13 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>Pitney Melody</u> | |



FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20811
REG. NO.

| | | | | | | | | | | |
|--|-------------------------|--|---|---|--|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Sherry Ann</i> <i>SANTAITI</i> | | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
<i>8-16</i> <i>79</i> <i>A</i> | | | 2b. HOUR
12 HOUR
<i>12</i> | | | | |
| 3. SEX
<i>Female</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>2-15-34</i> <i>45</i> YRS. | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
MONTHS DAYS HRS MIN. | 7. IF UNDER 1 YR.
MONTHS DAYS HRS MIN. | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
<i>8-16</i> <i>79</i> <i>12</i> | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Prince Georges</i> | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>35 Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>None</i> | | | | |
| 10. CITY OR TOWN OF DEATH
<i>74 Cheverly</i> | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Prince Georges General (D.O.A.)</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>None</i> | | |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
<i>35 Maryland Prince Georges Clinton</i> | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
<i>10909 Tyronne Drive</i> | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>160 Arthur Coulter</i> | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Vergie M. Richardson</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
<i>1 No</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>None</i> | | 17. INFORMANT
ADDRESS
<i>Joseph T. Santaiti Same as #13</i> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>1629 Epidermoid carcinoma of the lung</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Augusto P. Rodriguez</i> | | | TITLE (SPECIFY)
M.D. Deputy MEDICAL EXAMINER | | | DATE SIGNED
<i>8-16-79</i> | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
<i>Augusto P. Rodriguez, M.D.</i> | | | ADDRESS
<i>5009 Rayburn Ct., Camp Springs, Md. 20031</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>1000 BP Burial</i> | | | 23b. DATE
<i>8/20/79</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Resurrection Cemetery Clinton, P.G. Md.</i> | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>Lee Funeral Home Inc. 6633 Old Alexander Ferry Rd. Clinton, Md.</i> | | | | | 25a. DATE REC'D BY REGISTRAR
<i>AUG 24 1979</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Anthony McBrady</i> | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL EXAMINER NOTIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 7 20812 | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
CHERYL | | MIDDLE
SAUNDERS | | LAST
SAUNDERS | | 2a. DATE OF DEATH
MONTH DAY YEAR
08 08 79 | |
| 3 SEX
Female | | 4 RACE
Black | | 5 DATE OF BIRTH
MONTH DAY YEAR
10 11 47 | | 6 AGE (IN YEARS LAST BIRTHDAY)
31 | | 7b. HOUR
9:02A M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Florida | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGES | | MD. | |
| 10 CITY OR TOWN OF DEATH
Oxon Hill | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
7709 Den Meade Avenue | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
C&P Service Rep. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY
Prince Georges | | 13c. CITY OR TOWN
Oxon Hill | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
7709 Den Meade Avenue | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Hallet Saunders | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Martha Lovett | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES
no | | | |
| 16b. SOCIAL SECURITY NO.
578 64 7390 | | 17 INFORMANT ADDRESS
Hallet Saunders-father-7709 Den Meade | | | | | | | |
| 11 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Unknown</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Multiple Sclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>340-</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>years</u> | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22 I certify that (I) (this hospital) attended the deceased from <u>8/30</u> 19 <u>79</u> , to <u>8/10</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive <u>above</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>[Signature]</u> | | DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
8/10/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>S. J. [Signature]</u> | | 22e. ADDRESS
<u>6490 Candover Rd, Candover, Md.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial - Removal | | 23b. DATE
8/13/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Royal Palm Memorial Gardens | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
West Palm Beach, Florida | | | |
| 24 FUNERAL DIRECTOR
NAME
Stewart Funeral Home | | 24b. ADDRESS
4001 Benning Road | | 25a. DATE REC'D. BY REGISTRAR
AUG 16 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

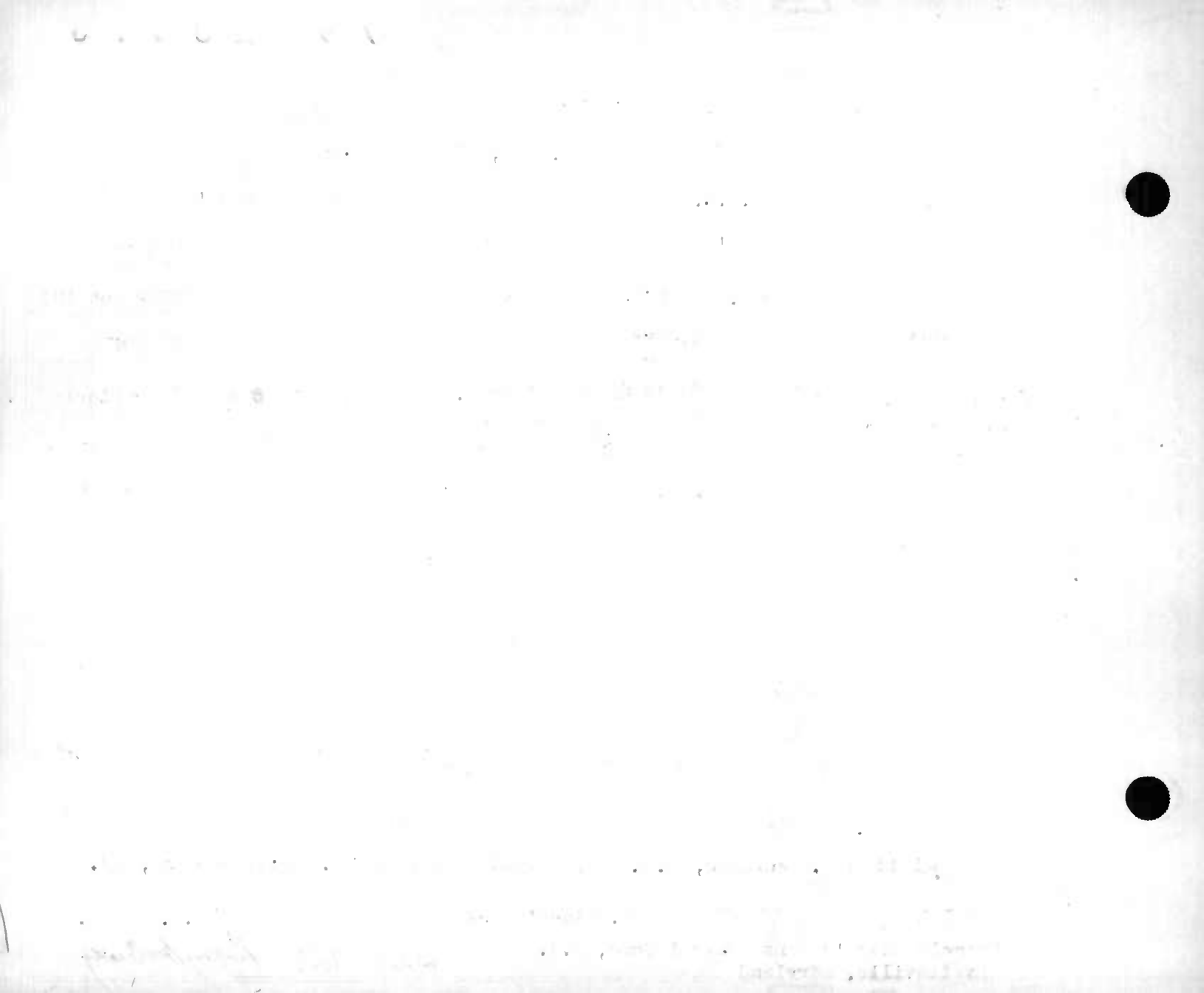


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 7 9 20813 | |
|--|--|--|--|---|---|
| 1. FOR
STATE
REGISTRAR | | CERTIFICATE OF DEATH | | | |
| 1 DECEASED NAME
(TYPE OR PRINT) | | | | 2a DATE OF DEATH | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR | HOUR |
| Leona M. SCHROEDER | | | | August 25, 1979 | 7:45A M |
| 3 SEX | | 4 RACE | 5. DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) |
| FEMALE | | WHITE | OCT. 23, 1909 | | 69 |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH |
| KENTUCKY | | U.S.A. | | | PRINCE GEORGE'S MD. |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b KIND OF BUSINESS OR INDUSTRY |
| LANHAM | | DOCTOR'S HOSPITAL OF PRINCE GEORGE | | CASHIER | DRUG STORE |
| 13a STATE | | 13b COUNTY | 13c CITY OR TOWN | 13d INSIDE CITY LIMITS? | 13e STREET ADDRESS |
| MARYLAND | | PRINCE GEO. | COLLEGE PARK | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 4706 CHEROKEE STREET Apt 104 |
| 14 FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | |
| JAMES D. BARNES | | | EDNA UNKNOWN | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | |
| NO | | 400 14 6305 | | Cindy L. Beall Same as #13 (Daughter) | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <i>Peritonitis</i> | | | | | 2 mos |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of colon</i> | | | | | 6 mos |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| 6/7/79 | | Carcinoma Bowel | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22 I certify that (I) (this hospital) attended the deceased from <i>June</i> 19 <i>79</i> to <i>Aug 25</i> 19 <i>79</i> that (I) (we) lost saw the deceased alive on <i>Aug 24</i> 19 <i>79</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b SIGNATURE | | DEGREE | | 22c DATE SIGNED | |
| <i>William B. Gunther</i> | | MD | | 8/25/79 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS | | | |
| William B. Gunther, M.D. | | 4917 Edgewood Rd. College Park, Md. | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b DATE | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION CITY OR TOWN COUNTY STATE |
| BURIAL | | 8/28/79 | Ft. Lincoln Cemetery | | Brentwood P.G. Md. |
| 24 FUNERAL DIRECTOR | | | 25a DATE REC'D. BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE |
| Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland | | | AUG 28 1979 | | <i>Henry McBrady</i> |



Medical Examiner notified and approved.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial transit permit. Then please receive carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

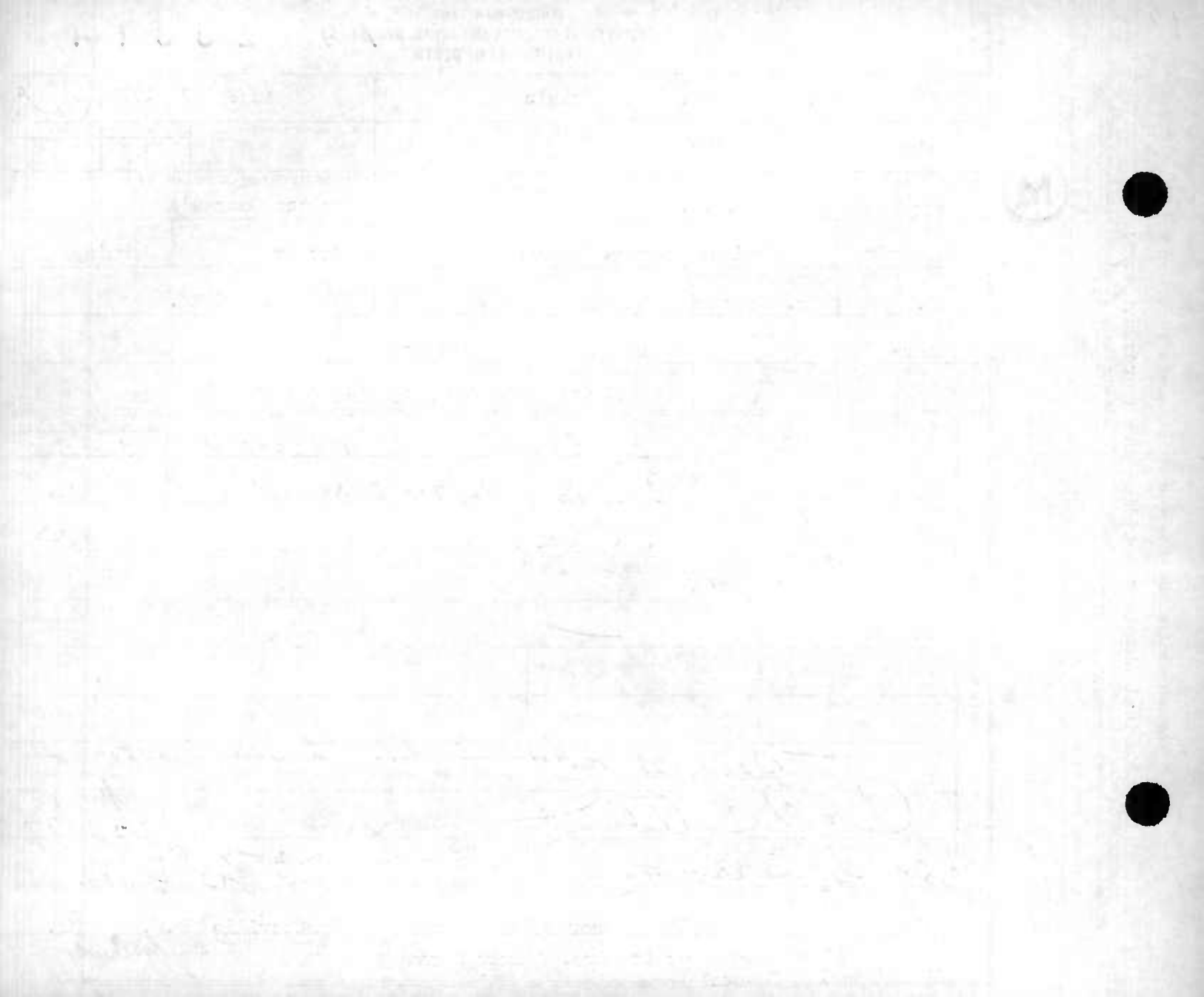
7 9 20814

REG. NO.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | Aug. 27 1979 | | 8:00 A.M. | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (IN YEARS LAST BIRTHDAY) | |
| Male | | White | | MONTH DAY YEAR
June 22 1895 | | 84 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | |
| Maryland | | U.S.A. | | | | Prince George's MD. | |
| 10 CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Cheverly | | Prince Georges General Hospital | | Farmer | | Farming | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Md. | | Pr. Georges | | Adelphi | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | No | | 217-36-6800 | |
| Henry Schulze | | Catherine Dean | | 17 INFORMANT | | ADDRESS | |
| | | | | Mabel L. Schulze (wife) | | Same | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>MYOCARDIAL Infarction</u>
410-
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>CORONARY Artery Disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>PROBIO Sclerosis</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 hrs.
5 yrs.
10 yrs. | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| None | | None | | None | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 22b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 22a. I certify that (I) (the hospital) attended the deceased from
saw the deceased alive on <u>August 27 1979</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
<u>Dr. [Signature]</u> | | 22c. DATE SIGNED
8/27/79 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HOROLD SORALINE | |
| 22e. ADDRESS
1352 UNIVERSITY BLVD
HARRISVILLE MD 21073 | | 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 8/29/79 | | George Washington | | Hyattsville P.G. Md. | |
| 24. FUNERAL DIRECTOR
NAME | | 11800 New Hampshire Ave. Silver Spring Md. | | 25. DATE REC'D. BY REGISTRAR | | 26. REGISTRAR'S SIGNATURE | |
| Hines/Rinaldi Funeral Home | | | | AUG 31 1979 | | | |

MEDICAL CERTIFICATION

BP



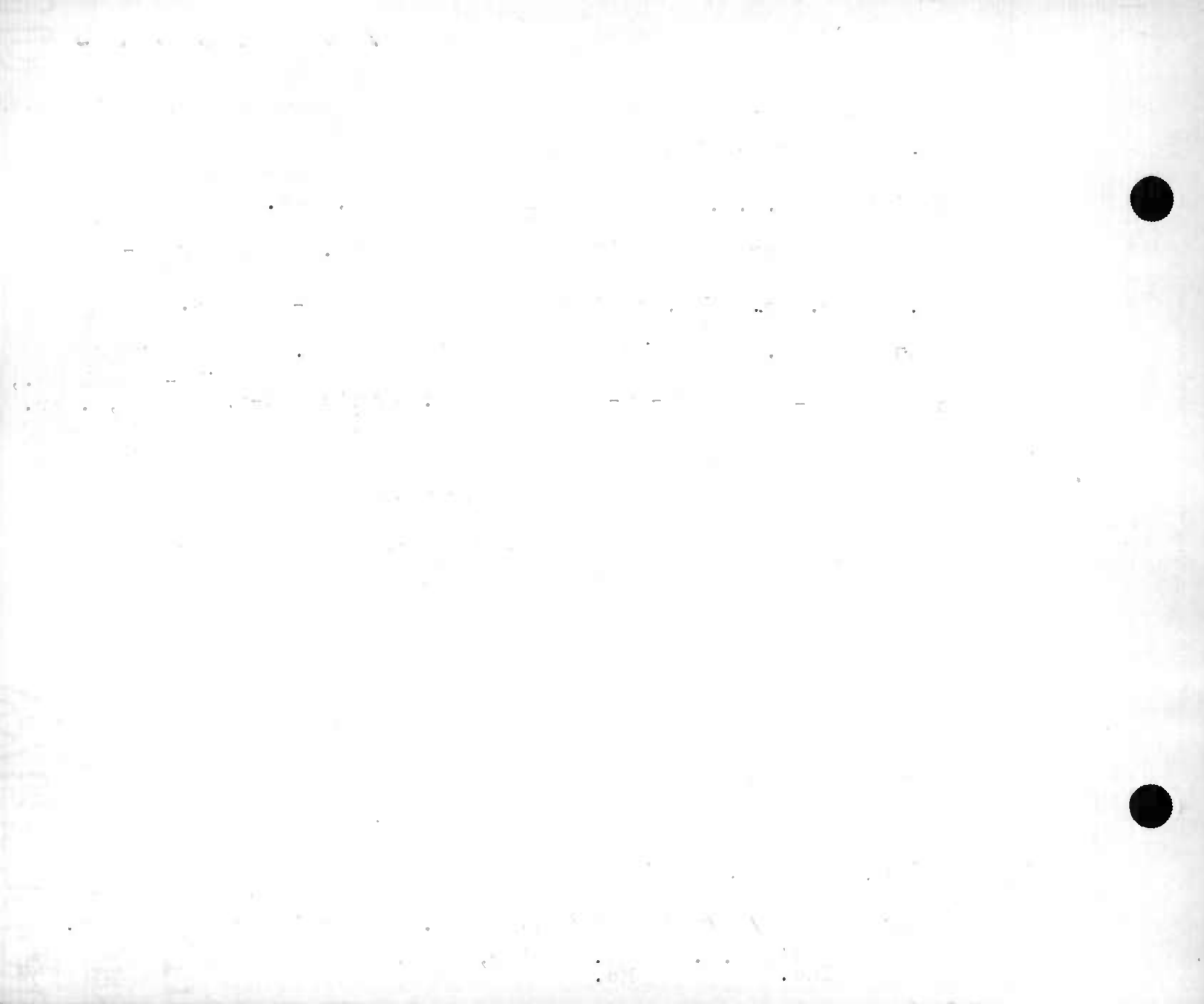
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 7 9 20815 | | | |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
Bessie Mae SCHWEICKERT | | | | 2a. DATE OF DEATH
August 24, 1979 | | 2b. HOUR
11:00p.m. | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
April 17 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Pr. Geo. | |
| 10. CITY OR TOWN OF DEATH
Lanham | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Doctors Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Saleslady | | 12b. KIND OF BUSINESS OR INDUSTRY
MD. | |
| 13a. STATE
Md. | | | | 13b. COUNTY
Pr. Geo. | | 13c. CITY OR TOWN
Mt. Rainier | |
| 14. FATHER'S NAME
John D. Meeks | | | | 15. MOTHER'S MAIDEN NAME
Lilly T. Farrar | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
577-16-5131 | | 17. INFORMANT
ADDRESS 5708 - Rebel Dr.,
Roger A. Schweickert - Charlotte, N. Car. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Uremia</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Acute Renal Failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Staphylococcal Sepsis, Fulminant massive pneumonia, weeks</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Chronic Brain Syndrome, decubiti</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>days</u>
<u>days</u> | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8-15</u> 19 <u>79</u> , to <u>8-24</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>8-24</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) sew the body after death. | | | | | | | |
| 22b. SIGNATURE
James J. Kim, M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
8/25/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
James J. Kim | | | | 22e. ADDRESS
10694 Campus Way S., Largo, Md. 20870 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
8/28/1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Nat. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington Va. | |
| 24. FUNERAL DIRECTOR
NAME
Nalley's F.H. Inc. | | | | ADDRESS
Mt. Rainier, Md. | | 25a. DATE REC'D. BY REGISTRAR
AUG 31 1979 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
P. J. McCready | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | |
|--|--|---|--|---|------------------------------------|--|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | | |
| HELEN MARY SCHYMAN | | | | 08-21-79 | | 8:28 AM | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | |
| FEMALE | | WHITE | | MONTH DAY YEAR | | 47 YRS. | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| PENNSYLVANIA | | U.S.A. | | | | PRINCE GEORGE'S MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| CHEVERLY | | PRINCE GEORGE'S GENERAL HOSPITAL | | | | KEY PUNCH OPERATOR | | LITTON CO. | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | |
| 13a. STATE | | | | | 13b. COUNTY | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS | |
| MARYLAND | | | | | PRINCE GEORGES BELTSVILLE | | | | 11706 CAVERLY AVENUE | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| FIRST MIDDLE LAST | | | FIRST MIDDLE LAST | | | | | | | |
| ALBERT DANIELS | | | MARY HUDOCK | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | | |
| NO | | | 204-24-9404 | | | WILLIAM R. SCHYMAN SAME AS 13 HUSBAND | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) POSTNECROTIC CIRRHOSIS | | | | | | | | | 5 yrs | |
| 5714 DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC HEPATITIS | | | | | | | | | 10 yrs | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| HEPATIC COMA | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| | | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 72, to 8-21, 19 79, that (I) (we) last saw the deceased alive on 8-21, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | 22c. DATE SIGNED | | |
| Barry Epstein M.D. | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 8-21-79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | |
| BARRY EPSTEIN, M.D. | | | | | | 6201 GREENBELT RD, COLLEGE PARK, MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| BURIAL | | | 8/25/79 | | ST. AGNES CHURCH CEM. | | SELLERSVILLE PENNSYLVANIA | | | |
| 24. FUNERAL DIRECTOR
NAME | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| FRANCIS J. COLLINS | | | | | | AUG 28 1979 | | [Signature] | | |
| 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

500 W. 11th St., St. Louis, Mo. 63101

FRANCIS J. COLLINS

2/25/79

BURIAL

ST. AGNES CHURCH CEM. BELLEVILLE

ST. AGNES CHURCH CEM. BELLEVILLE

WY. ESTATE, INC.

Francis J. Collins

WY

6-11

ST. AGNES CHURCH CEM. BELLEVILLE

12-19-77

27-1

NO

104-24-9402

WILLIAM R. SCHWANN SAME AS 12 WIFE

ALBERT

CANTILE

WABA

HUDON

HARVARD PRINCE GEORGE BELLEVILLE

X

11706 CANTILE AVENUE

CANTILE

PRINCE GEORGE BELLEVILLE

KEN PRINCE OPERATOR

LITTON CO.

TENNESSEE

U.S.A.

PRINCE GEORGE'S

FEMALE

WHITE

OCT. 17, 1977

XX

17

WABA

SCHWANN

08-1-77

8-1-77



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 9 20817 | |
|--|--|--|--|--|--|---|---|--|---|---------------------|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | |
| 1 DECEASED NAME (TYPE OR PRINT)
JESSE SCOTT SEE | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
08 26 79 | | | | | 2b. HOUR
2-45 PM | |
| 3 SEX
MALE | | 4 RACE
WHITE | | 5 DATE OF BIRTH MONTH DAY YEAR
April 8, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGES COUNTY MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Laurel | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
GREATER LAUREL BELTSVILLE HOSPITAL | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Wildlife Care | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S.D.A. | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE Maryland 13b COUNTY Howard | | | | | 13c. CITY OR TOWN
Jessup | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
8196 Mission Rd. | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Clarence C. See | | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Lucy See | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No. | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
236-14-8304 | | 17 INFORMANT
Mary M. See | | | ADDRESS
same as #13 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST
410-
DUE TO, OR AS A CONSEQUENCE OF
(b) ANTECEDENT MYOCARDIAL INFARCTION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-26- 19 79 , to 8-26- 19 79 , that (I) (we) last saw the deceased alive on 7-26- 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did <input checked="" type="checkbox"/> view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>M.H. Chaudhry</i> | | | | | DEGREE
M.D. | | | 22c. DATE SIGNED
8-26-79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M.H. CHAUDHRY, M.D. | | | | | 22e. ADDRESS
3450 FT. MEAD. Rd. Laurel Md. 20810 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
8/29/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Olivet Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Moorefield, Hardy, W. Va. | | | | |
| 24 FUNERAL DIRECTOR
FLECK LAUREL FUNERAL HOME, INC.
7601 Sandy Spring Rd. Laurel, Md. 20810 | | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 27 1979 | | 25b. REGISTRAR'S SIGNATURE
<i>Anthony Kelly</i> | | | | |

MEDICAL CERTIFICATION

V. T. S. O. S.

22

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20818

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|---|---|--|---|---|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
Charles Jacob SELLNER | | | 2a DATE OF DEATH
MONTH DAY YEAR
08/ 12/ 79 | | | 2b HOUR
12:45p M | | | |
| 3 SEX
Male | | 4 RACE
Caucasian | | 5 DATE OF BIRTH
MONTH DAY YEAR
08 08 04 | | 6 AGE (IN YEARS LAST BIRTHDAY)
74 YRS | | 7 IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash. D.C. | | 7b CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Prince Georges MD. | | | |
| 10 CITY OR TOWN OF DEATH
Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Southern Maryland Hospital Center | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Dispatcher | |
| 13a STATE
Md. | | | 13b. CITY OR TOWN
P.G. | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS
8505 Rockwell Drive | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
William Thomas Sellner | | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret M. Talbert | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b SOCIAL SECURITY NO.
None | | 17 INFORMANT
ADDRESS
Olive V. Sellner Same as #13 | | | | |

| | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-pulmonary failure
4029
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Hypertension & Cardiac arrhythmias
DUE TO, OR AS A CONSEQUENCE OF
(c) Diabetes Mellitus
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a DATE OF OPERATION
8/6/79 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Ch. Cholecystitis & white | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 8/5 , 19 79 , to 8/12 , 19 79 , that (I) (we) last saw the deceased alive on 8/12 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
J.S. Gill | | | | DEGREE
MD | | | | 22c. DATE SIGNED
8/12 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J.S. GILL, MD | | | | 22e ADDRESS
Southern Maryland Hospital Clinton, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
8/15/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland P.G. Md. | | | |
| 24 FUNERAL DIRECTOR
NAME
Lee Funeral Home Inc | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 21 1979 | | 25b. REGISTRAR'S SIGNATURE
Anthony McCreedy | | | |
| 6633 Old Alexander Ferry Rd. Clinton, Md. | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Charles Jacobus 2412751 121 32 12:42M

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

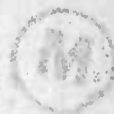
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|
| 1 - FOR
STATE
REGISTRAR | | | | 7 9 2 0 8 1 9
REG. NO. | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
Edward Franklin Shafer | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
August 28, 1979 | | | | 2b. HOUR
4:00p M | |
| 3 SEX
Male | | 4 RACE
Caucasian | | 5 DATE OF BIRTH
MONTH DAY YEAR
March 12, 1909 | | 6 AGE (IN YEARS LAST BIRTHDAY)
70 YRS | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince George's MD. | | | |
| 10. CITY OR TOWN OF DEATH
Riverdale | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Eugene Leland Memorial Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
None | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
Riverdale | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
Franklin A. M. Shafer | | | | 15 MOTHER'S MAIDEN NAME
Mattie Young | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
XXXXXXXXXX | | 17 INFORMANT
ADDRESS
22 N. Market Street
Mrs. Sue Ann Masser Frederick, Md. 21701 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute sepsis with shock</u>
5679
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Acute peritonitis (pseudomonas)</u>
(c) <u>Chronic obstructive lung disease, Congestive heart failure</u>
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH
Three days
Three days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 6</u> , 19 <u>66</u> , to <u>August 28</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>August 28</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Carl J. Houmann | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
Aug. 29, 1979 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Carl J. Houmann, M. D. | | | | 22e. ADDRESS
4404 Queensbury Road, Riverdale, Md. 20840 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
8-30-1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Crematory | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Washington, D.C. | | | |
| 24. FUNERAL DIRECTOR
Robert E. Bailey & Son | | | | 1201 N. Market Street
Frederick, Md. 21701 | | 25a. DATE REC'D. BY REGISTRAR
SEP 4 1979 | | 25b. REGISTRAR'S SIGNATURE | |

6501



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | 7 9 2 0 8 2 0 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
Edna M SINGLETON | | | | 2a. DATE OF DEATH MONTH DAY YEAR
August 31, 1979 | | 2b. HOUR A M
10:30 A | | | |
| 3. SEX
Female | | 4. RACE
Black | | 5. DATE OF BIRTH MONTH DAY YEAR
5-10-14 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ga. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince George County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Glenn Dale | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Glenn Dale Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
D.C. | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Washington | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
3111 Newton St. N.E. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Henry Bines | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Grace Haynes | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
258/30/4038 | | 17. INFORMANT ADDRESS
Silas Singleton 1109 Penn St. N.E. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Renal Failure
2505
DUE TO, OR AS A CONSEQUENCE OF
(b) Diabetic Neuropathy
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1-week
years | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Cervical spondylosis with quadriparesis | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 3 , 19 79 , to August 31 , 19 79 , that <input checked="" type="checkbox"/> (we) lost <input type="checkbox"/> the deceased alive on August 31 , 19 79 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
James Wills, M.D. | | | | DEGREE
M.D. | | 22c. DATE SIGNED
August 31, 1979 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
James W. Wills, M.D. | | | | 22e. ADDRESS
Glenn Dale Hospital
Glenn Dale, Maryland 20769 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
9-7-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Washington National | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Washington D.C. | | | |
| 24. FUNERAL DIRECTOR
L. L. Williams | | | | ADDRESS
814 - 4th St. N.W. 20001 | | DATE REC'D BY REGISTRAR
SEP 14 1979 | | | |

BP

Female

Black

5-10-14

62

Ga.

U.S.

*

D.C.

Henry Bines

No

Washington

*

Grace Haynes

Slas Singleton 1109 Penn St. N.E.

3111 Newton St. N.E.

Houswife



BP

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MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 20821
REG. NO. | | |
|--|-------------------------|---|--|---|---|--|---|---|--|--|---|----------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) June Anita SKLAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED 8-1 1979 | | 2b. HOUR
M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH 12 DAY 9 YEAR 33 | | 6. AGE (IN YEARS)
LAST BIRTHDAY 45 YRS. | IF UNDER 1 YR.
MONTHS 4 DAYS 4 | | IF UNDER 24 HRS.
HOURS 4 MIN 4 | | 2c. DATE PRONOUNCED DEAD
MONTH 8 DAY 1 YEAR 1979 | | 2d. HOUR
M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
LA, Calif | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | BALTIMORE CITY OR COUNTY OF DEATH
Baltimore MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Cheveely | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN NURSING HOME, GIVE STREET ADDRESS)
P.G. Gen Hosp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY
ret | | | | |
| 13a. STATE
Md | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
Beltsville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
11318 Cherry Hill Rd | | | 20705 | |
| 14. FATHER'S NAME
FIRST WILSON MIDDLE WILSON LAST WILSON | | | | | 15. MOTHER'S MAIDEN NAME
FIRST UNK MIDDLE UNK LAST UNK | | | 16. SOCIAL SECURITY NO.
568-405783 | | | 17. INFORMANT
Mr. Dennis M. Keith | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) YES | | | | | 16b. SOCIAL SECURITY NO.
568-405783 | | 17. INFORMANT
Mr. Dennis M. Keith | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4029 IMMEDIATE CAUSE (a) My performance cardiac cerebral vascular disease | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | |
| ACTUAL SIGNATURE
August P. Rodriguez | | | | TITLE (SPECIFY)
MD | | | | MEDICAL EXAMINER
August P. Rodriguez | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
August P. Rodriguez | | | | ADDRESS
5009 Rainburn Ct. Camp Springs | | | | DATE SIGNED
8-2-79 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | | | 23b. DATE
8-7-79 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Lee Crematory | | | | |
| 24. FUNERAL DIRECTOR
NAME
WIRDE F.H. | | | | ADDRESS
Ridgely, Md | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 10 1979 | | | | |
| 25b. REGISTRAR'S SIGNATURE
Henry McBrady | | | | 25c. LOCATION
CITY OR TOWN
WASH. D.C. | | | | 25d. COUNTY
DC | | | | |

1 2 3 4

THE UNIVERSITY OF CHICAGO
LIBRARY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

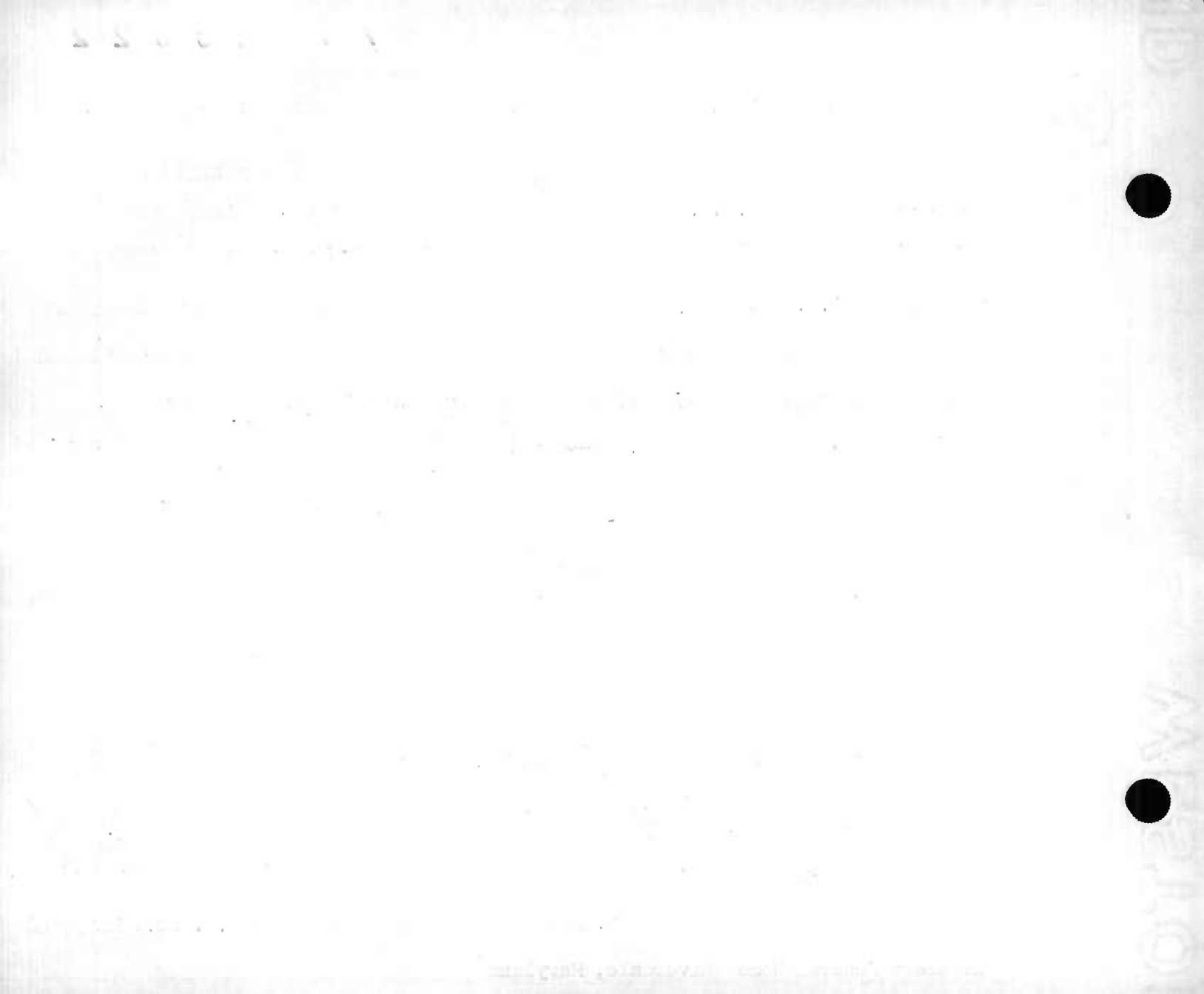
FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

9 20822

| | | | | | | | |
|---|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
HILDA ELIZABETH SLYE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
August 14, 1979 | | | 2b. HOUR
6.50 P | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
December 5, 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY)
54 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince Georges County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Lanham | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Doctors Hospital of Pr. Geo. | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Co. Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. STATE
Maryland | | 13b. COUNTY
P.G. Co. | | 13c. CITY OR TOWN
Riverdale | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Olof - Olsen | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Adele - Seadale | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
None | | 17. INFORMANT
ADDRESS
Rev. David E. Slye Sr. Same as # 13. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3 days</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Diabetes Mellitus</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>11 Aug</u> 19 <u>79</u> , to <u>14 Aug</u> 19 <u>79</u> , that (1) (we) last saw the deceased alive on <u>14 Aug</u> 19 <u>79</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>William A. Wimsatt</u> | | DEGREE
<u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>14 Aug 79</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
William A. Wimsatt, M.D. | | 22e. ADDRESS
8150 Lakecrest Drive, Greenbelt, Md. 20770 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
8/17/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood, P.G. Co., Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Chambers Funeral Home | | ADDRESS
Riverdale, Maryland | | 25a. DATE REC'D. BY REGISTRAR
AUG 20 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>John J. McCreedy</u> | |



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

9

20823

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|---|--|
| 1 DECEASED NAME
(TYPE OR PRINT) DORIS M. SMALLWOOD | | | 2a DATE OF DEATH
MONTH DAY YEAR
8-18-79 | | | 2b HOUR
10²⁰ AM | | | | |
| 3 SEX
FEMALE | | 4 RACE
CAUCASIAN | | 5 DATE OF BIRTH
MONTH DAY YEAR
6 11 28 | | 6 AGE (IN YEARS LAST BIRTHDAY)
51 | | 7a IF UNDER 1 YEAR
MONTHS DAYS
YRS | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington DC | | 7b CITIZEN OF WHAT COUNTRY?
USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGE'S MD | | | | |
| 10 CITY OR TOWN OF DEATH
CLINTON | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
So. MD HOSPITAL CENTER | | | | 12a USUAL OCCUPATION
(TYPE IF WORK FORMERLY OF WORKING)
Cafeteria Assistd of Educa | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE
VA | | | 13b COUNTY
moreland | | | 13c CITY OR TOWN
COLONIAL BEACH | | | 13d INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
George E Corbin | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Virginia Lee Grimes | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b SOCIAL SECURITY NO.
579-32-3799 | | | 17 INFORMANT
ADDRESS
William Smallwood, Sr. Same as #13 | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Adenocarcinoma
1629
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Mets to Liver and Bone - Tymphoid Nodes
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 mo | | | | | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Electrolyte imbalance secondary to probable adrenal insufficiency | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a I certify that (I) (this Hospital) attended the deceased from 8/17 19 79 to 8/18 19 79 , that (I) (we) last saw the deceased alive on 8/17 19 79 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b SIGNATURE
George W. Wathen MD | | | DEGREE
MD | | | 22c DATE SIGNED
8/18/79 | | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
G. W. WATHEN MD. | | | 22e ADDRESS
4400 SAMPSON MARLOW Wgt Wld. | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b DATE
8-21-1979 | | 23c NAME OF CEMETERY OR CREMATORY
Resurrection Cem | | 23d LOCATION
CITY OR TOWN COUNTY STATE
Clinton Maryland | | | |
| 24 FUNERAL DIRECTOR'S NAME
Robert E Wilhelm | | | | | 24b ADDRESS
Suitland Maryland | | 25a DATE REC'D. BY REGISTRAR
AUG 22 1979 | | 25b REGISTRAR'S SIGNATURE
Robert McCreedy | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem examination should be requested by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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22



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR 115 ME (5))
30M 7/73



| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 20824
REG. NO. | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Charles Irving SMITH</i> | | | | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <i>8-4 1979</i> | |
| 3. SEX <i>Male</i> 4. RACE <i>White</i> 5. DATE OF BIRTH
MONTH DAY YEAR <i>7-13-11 68</i> 6. AGE (IN YEARS)
(LAST BIRTHDAY) MONTHS DAYS HOURS MIN <i>28</i> YRS. | | | | | | | | | | 2c. DATE PRONOUNCED DEAD <i>8-4 1979</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Wash., D. C.</i> 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Prince Georges</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Cheverly</i> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Prince George's Gen. Hospital</i> | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Policeman - retir.</i> 12b. KIND OF BUSINESS OR INDUSTRY <i>D.C. Police</i> | |
| 13a. STATE <i>Maryland</i> 13b. COUNTY <i>Pr. George's</i> 13c. CITY OR TOWN <i>Temple Hills</i> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <i>3308 Carlton Avenue</i> | | | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST <i>Charles Smith</i> 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST <i>Unknown Unknown</i> | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i> 16b. SOCIAL SECURITY NO. <i>579-09-6285</i> 17. INFORMANT ADDRESS <i>Upper Marl., Md.</i> | | | | | | | | | | 17. INFORMANT ADDRESS <i>Robert Smith 10712 Brookwood Ave.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
<i>4354</i> IMMEDIATE CAUSE (a) <i>Cardio myo pathy</i>
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | |
| 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | |
| 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> M.D. TITLE (SPECIFY) <i>MD</i> MEDICAL EXAMINER DATE SIGNED <i>8-4-79</i> | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez</i> ADDRESS <i>5009 Poydram Court, Chevy Chase</i> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> 23b. DATE <i>8/7/79</i> 23c. NAME OF CEMETERY OR CREMATORY <i>Resurrection Cemetery</i> 23d. LOCATION CITY OR TOWN <i>Clinton Pr. George Maryland</i> STATE | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>George P. Kalas</i> ADDRESS <i>Oxon Hill, Md.</i> 25a. DATE REC'D. BY REGISTRAR <i>AUG 8 1979</i> 25b. REGISTRAR'S SIGNATURE <i>Anthony A. Brady</i> | | | | | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| FOR STATE REGISTRAR | | | | | | | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 20825 | |
|--|--|-------------------------------|--|---|--|--|--|---|--|---|--|---|--|--|--|----|--|--|--|--------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>W. Williams L. SMITH</i> | | | | | | | | | | 2a. DATE KNOWN OF DEATH MATED <i>8-8-79</i> | | | | | | | | | | 2b. HOUR <i>10</i> | |
| 3. SEX <i>Male</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH <i>10-14-32</i> | | 6. AGE (IN YEARS) <i>46</i> YRS | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED <i>8-9-79</i> | | 2d. HOUR <i>12</i> | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>North Carolina</i> | | | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Prince Georges</i> | | | | MD | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Cheverly</i> | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <i>Prince Georges Gen. Hosp.</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Plumber</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Plumbing</i> | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE <i>Maryland</i> | | 13b. COUNTY <i>Pr. George</i> | | 13c. CITY OR TOWN <i>Marlow Hgts</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS <i>4109 Murdock St.</i> | | | | | | | | | | | | | |
| 14. FATHER'S NAME <i>William L. Smith</i> | | | | | | | | | | 15. MOTHER'S MAIDEN NAME <i>Hazel Myers</i> | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i> | | | | 16b. SOCIAL SECURITY NO. <i>240-40-2199</i> | | 17. INFORMANT ADDRESS <i>Hazel Henderson (Mother) As in item 13a</i> | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
<i>5715</i> IMMEDIATE CAUSE (a) <i>Agutic cerebrosis</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i> | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: <i>Natural causes</i> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Augusto P. Rodriguez</i> | | | | TITLE (SPECIFY) <i>Deputy</i> | | | | MEDICAL EXAMINER | | | | DATE SIGNED <i>8-9-79</i> | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <i>Augusto P. Rodriguez, M.D.</i> | | | | ADDRESS <i>5009 Rayburn Ct., Camp Springs, Md. 20031</i> | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i> | | | | 23b. DATE <i>8-10-1979</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i> | | | | 23d. LOCATION CITY OR TOWN <i>Suitland</i> COUNTY <i>P.G.</i> STATE <i>Maryland</i> | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>George P. Kalas</i> | | | | ADDRESS <i>6160 Oxon Hill RD, Oxon Hill, Md.</i> | | | | 25a. DATE REC'D. BY REGISTRAR <i>AUG 13 1979</i> | | | | | | | | | | | | | |

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DHM-17
(VR A15 ME (5))
15M 7/76



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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH20826
REG. NO.1- STATE
REGISTRAR

| | | | | | | |
|---|----------------------------------|---|--|--|--|---|
| 1 DECEASED NAME
(TYPE OR PRINT)
Bernard C. Snellings | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
8 13 19 79 | | | 2b. HOUR
M
7:10 P M |
| 3 SEX
Male | 4 RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
June 29, 1910 | 6. AGE (IN YEARS)
LAST BIRTHDAY
69 YRS. | IF UNDER 1 YR.
MONTHS DAYS
0 0 | IF UNDER 24 HRS.
HOURS MIN
0 0 | 2c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
8 13 19 79 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington D C | | 7b. CITIZEN OF WHAT COUNTRY?
U S A | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince George's County, MD |
| 10. CITY OR TOWN OF DEATH
Cheverly | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Prince George's General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)
Iron worker | | 12b. KIND OF BUSINESS OR INDUSTRY
Kenmar Steel Co. |
| 13a. STATE
Md | | | 13b. COUNTY
Pro Georges | 13c. CITY OR TOWN
Riverdale | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
6612 Hillwood Drive | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John C Snellings | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Minnie A Selph | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
no | | | 16b. SOCIAL SECURITY NO.
225 05 2402 | | 17. INFORMANT
ADDRESS
Ellen R Snellings Riverdale, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | |
| ACTUAL SIGNATURE
Virginia L. Dolan | | TITLE (SPECIFY)
Assistant | | DATE SIGNED
8/15/79 | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Virginia L. Dolan, M.D. | | ADDRESS
111 Penn Street | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
Aug 17, 1979 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland Pro Georges Md. | | |
| 24. FUNERAL DIRECTOR
NAME
F. Gasch's Sons P A | | ADDRESS
Hyattsville, Md | | 25a. DATE REC'D. BY REGISTRAR
AUG 17 1979 | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|---|--|--|---|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) JAMES J. E. SNOWDEN | | | | | 2a. DATE OF DEATH
MONTH 8 DAY 4 YEAR 1979 | | | | | 2b. HOUR
9:45 AM | |
| 3. SEX
M | | 4. RACE
B | | 5. DATE OF BIRTH
MONTH 1-24 DAY 1905 YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. 8 MONTHS 5 DAYS | | | 7. IF UNDER 1 YEAR
IF UNDER 23 HRS
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince George's MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Beltsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
7602 Old Muirkirk Rd. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MD. State Gov't. | | | 12b. KIND OF BUSINESS OR INDUSTRY
Retired | | |
| 13a. STATE
Md. | | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
Beltsville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
7602 Old Muirkirk Rd. | | |
| 14. FATHER'S NAME
FIRST Benjamin MIDDLE Snowden LAST | | | | | 15. MOTHER'S MAIDEN NAME
FIRST Mary MIDDLE Matthews LAST | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO.
705-12-6489 | | 17. INFORMANT ADDRESS
Virginia Snowden-Same as # 13 above | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
4148
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ASCVD
DUE TO, OR AS A CONSEQUENCE OF
(c) Hypertension | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1977
1972
1960 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Stroke 1977, Amputation of leg 1977 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/9/70 , 19 70 , to 7/9 , 19 79 , that (I) (we) last saw the deceased alive on 7/9 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
J. W. Warren MD | | | DEGREE | | | 22c. DATE SIGNED
8/7/79 | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. W. Warren MD | | |
| 22e. ADDRESS
14 S. Washington & Sons | | | 22f. ADDRESS
14 S. Washington & Sons | | | 22g. ADDRESS
14 S. Washington & Sons | | | 22h. ADDRESS
14 S. Washington & Sons | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE
8-9-79 | | 23c. NAME OF CEMETERY OR CREMATORY
MARYLAND NAT'L. CEM. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BELTSVILLE MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
H. S. WASHINGTON & SONS | | | ADDRESS
4925 BURROUGHS AVE. N.E. | | | 25. DATE REC'D. BY REGISTRAR
AUG 13 1979 | | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

12603

RECEIVED
FEB 10 1964

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FEB 10 1964

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FEB 10 1964

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FEB 10 1964

RECEIVED
FEB 10 1964

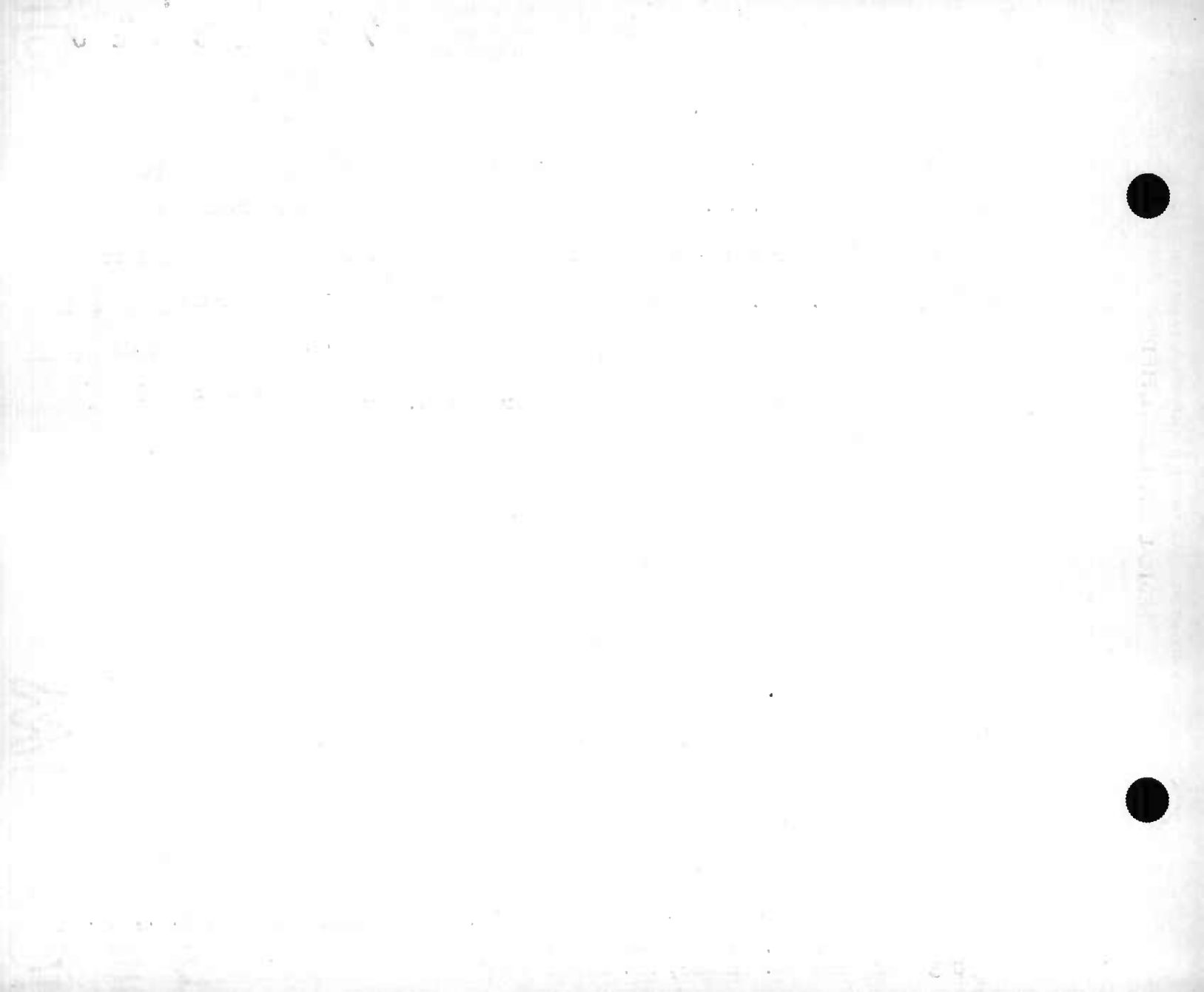
MEDICAL EXAMINER NOTIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of occurrence.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|---|---|---|------------------------------------|--|
| 1. FOR STATE REGISTRAR | | | 7 20828 | | | | REG. NO. | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR |
| Donald L. Spittle | | | | | | 8-7-79 | | | 5:20 P.M. |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR IF UNDER 24 HRS | |
| Male | | Caucasian | | Sept. 20, 1927 | | 51 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Virginia | | U.S.A. | | | | Prince Georges MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Cheverly | | Prince Georges General Hospital | | | | Agent | | Insurance | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS |
| Maryland | | | Pr. Geo. | | Largo | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 208 Colton Street |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | |
| John Spittle, Sr | | | Hazel Davis | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | |
| yes | | | WW II | | 230-20-8672 | | Virginia H. Spittle Same As # 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Ruptured Esophageal Varices | | | | | | | | | minutes |
| 5712 | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Alcoholic Liver Cirrhosis with its Complications | | | | | | | | | Years |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| N/A | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| N/A | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | STATE |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-16-1977 to 7-25-1977, that (I) (we) lost saw the deceased alive on 7-25-1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | | 22c. DATE SIGNED | | |
| James J. Kim, M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 8-9-79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | |
| James J. Kim | | 10694 Campus Way S., Largo, Md. 20870 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 10 AUG 79 | | Lakemont Memo. Gdns | | Davidsonville, A.A., Md. | | | |
| 24. FUNERAL DIRECTOR NAME | | 24b. DATE | | 24c. NAME OF CEMETERY OR CREMATORY | | 24d. LOCATION CITY OR TOWN | | 24e. REGISTRAR'S SIGNATURE | |
| Robert G. Beall Funeral Home | | AUG 13 1979 | | WDY | | AUG 13 1979 | | Morty McCreedy | |
| 9013 Annapolis Rd. Lanham, Md. 20801 | | | | | | | | | |

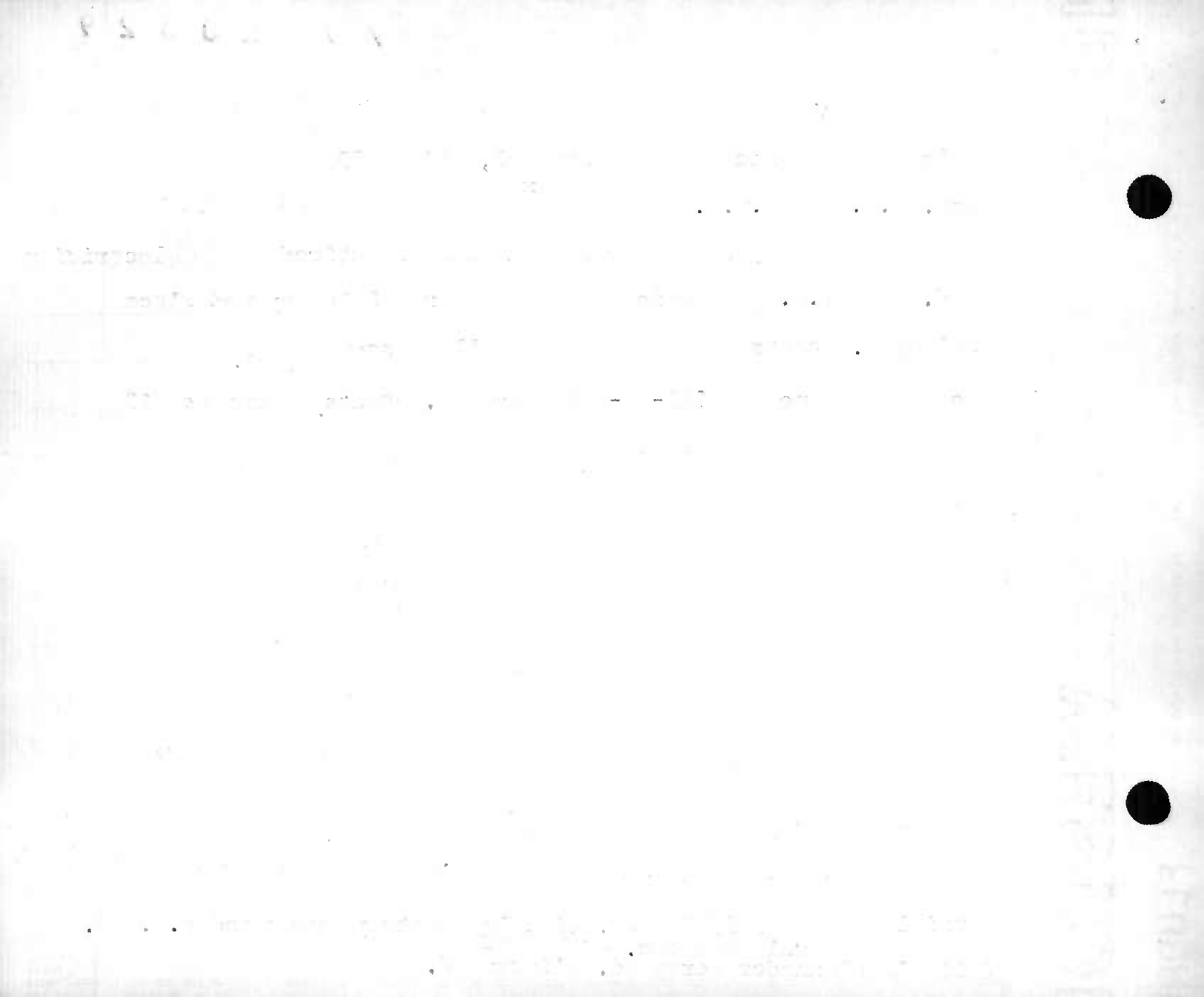


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 7 9 2 0 8 2 9 | | REG. NO. | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
EDWIN J STAATS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
AUGUST 13 1979 | | | 2b. HOUR
3:26A _M | | | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 13, 1904 | | 6 AGE (IN YEARS (LAST BIRTHDAY))
75 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince George's MD. | | | |
| 10. CITY OR TOWN OF DEATH
Lanham | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Doctors' Hospital of Pr. Geo. Co. | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Electrician | | |
| 13a. STATE
Md. | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
Bowie | | 14. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 15. STREET ADDRESS
3810 Weywood Place | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Julius C. Staats | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ella Dassow | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
None | | 17. INFORMANT
Sarah W. Staats | | ADDRESS
Same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Septicemia, Respiratory Failure, Renal Failure</u>
486-
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>Renal Failure 2° to Septicemia, Pneumonia</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/12</u> 19 <u>78</u> to <u>8/13</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>8/12</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Gerard P. Champaloux</u> | | | | DEGREE
<u>M.D.</u> | | | 22c. DATE SIGNED
8/13/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Gerard P. Champaloux, M.D. | | | | 22e. ADDRESS
6911 Laurel-Bowie Rd., #209, Bowie, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
8/15/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood P.G. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Lee Funeral Home Inc. | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 21 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>Anthony McCreedy</u> | | | |
| 6633 Old Alexander Ferry Rd. Clinton Md. | | | | | | | | | |





| DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 20830 | | |
|---|----------------------|--|--|---|---|---|--|--|-------------------|---|--|-------------------|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | |
| 1. DECEASED NAME
(TYPE OR PRINT) Therman E. Statom | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTI-MATED 8-2 1979 | | 2b. HOUR M |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH
MONTH DAY YEAR 10-12-25 53 | | 6. AGE (IN YEARS)
LAST BIRTHDAY MONTHS DAYS HOURS MIN 53 YRS. | IF UNDER 1 YR. | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD 8-2 1979 | | 2d. HOUR M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince Georges MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3801 Kenilworth Avenue | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Public Affairs | | 12b. KIND OF BUSINESS OR INDUSTRY Manager | | | | |
| 13a. STATE Maryland | | | | | | | | | | 13b. COUNTY Bladensburg | | |
| 13c. CITY OR TOWN PG | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET ADDRESS 3801 Kenilworth Avenue | | | | | | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST Joseph C. Statom | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Arlene Carwise | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes | | | | 16b. SOCIAL SECURITY NO. 266 24 1294 | | 17. INFORMANT 227 Jefferson Street, N.W. Mrs. Jodellano Statom | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Sclerotic Cardiovascular Disease
4292
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusta P. Rodriguez | | | | TITLE (SPECIFY) M.D. Rodriguez | | | | MEDICAL EXAMINER | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusta P. Rodriguez | | | | ADDRESS 5009 Rayburn Ct., Camp Springs | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL 23b. DATE Burial 8/7/79 | | | | 23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE Suitland, Maryland | | | | |
| 24. FUNERAL DIRECTOR
NAME Stewart Funeral Home | | | | 4001 Benning Road, N.E. | | | | 25a. DATE REC'D. BY REGISTRAR AUG 8 1979 | | 25b. REGISTRAR'S SIGNATURE Augusta P. Rodriguez | | |

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RECEIVED
FEB 10 1964
U.S. AIR FORCE

100-100000



100-100000



Medical Examiner Notified

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|---|--|--|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE OF DEATH | | 2b. HOUR | |
| FIRST MIDDLE LAST
MINNIE I. STEPHANSON | | MONTH DAY YEAR
8-23-79 | | 10:20 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | |
| Female | White | MONTH DAY YEAR
10 16, 89 | 89 YRS. | MONTHS DAYS | HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| WASHINGTON DC. | USA | | PRINCE GEORGES MD | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| HYATTSVILLE | MANOR CARE HYATTSVILLE NURSING CENTER | | Housewife | | OWN Home |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. CITY OR TOWN | 13c. STREET ADDRESS | | |
| 13a. STATE COUNTY
Maryland Prince Geo. | | 13b. OXEN HILL | 13c. 13314 Fort Washington Rd. | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST
William Stevenson | | FIRST MIDDLE LAST
Emily De Shields | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 577 05 4731 D | | Charles Stephanson Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>486-</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) <u>Pneumonia - Congestive Heart Failure</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2-3 hrs</u>
<u>1-2 days</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 1956</u> to <u>AUG 23 1979</u> , that (I) (we) last saw the deceased alive on <u>July 16 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. | | 22b. SIGNATURE
<u>Robert B. Irey</u> | | 22c. DATE SIGNED
<u>Aug 23 1979</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| ROBERT B. IREY | | 11161 New Hampshire Ave | | Silver Spring Md | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 8/27/79 | | Glenwood Cemetery | |
| 23d. LOCATION CITY OR TOWN | | 23e. COUNTY | | 23f. STATE | |
| Washington D.C. | | | | | |
| 24a. FUNERAL DIRECTOR'S NAME | | | 24b. DATE REC'D. BY REGISTRAR | | |
| Francis Gasch's Sons Funeral Home, P.A.
Hyattsville, Maryland | | | AUG 27 1979 | | |
| 25a. REGISTRAR'S SIGNATURE | | | 25b. REGISTRAR'S SIGNATURE | | |
| | | | notary/mcbride | | |

BP

1888

STATION

98

STEWARTSON, Emily

Register - continued, 1888

STATION

STATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4/1
2/3
2001
3

MEDICAL CERTIFICATION
2
9
1

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|--|---|---|---------------------------------|---|--|
| <div> <div>FOR
STATE
REGISTRAR</div> <div>7 9 2 0 8 3 2</div> <div>REG. NO.</div> </div> | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
JOHN ALBERT STEWART | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
August 12, 1979 | | 2b. HOUR
10:20
P M | | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 30, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78
YRS | | <div> <div>IF UNDER 1 YEAR</div> <div>IF UNDER 24 HRS</div> </div> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | <div> <div>MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div> </div> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince George County
MD. | | | |
| 10. CITY OR TOWN OF DEATH
Glenn Dale | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Glenn Dale Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY
Trucking | |
| 13a. STATE
MD. | | 13b. COUNTY
Wash., D.C. | | 13c. CITY OR TOWN
Wash., D.C. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
223 Tennessee Ave., S.E. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Stewart | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Louise Simmons | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
577-12-0779 | | 17. INFORMANT
ADDRESS
Wash., D.C.
Mary E. Stewart-wife-223 Tennessee Ave., N.E. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Embolism | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
sudden | |
| <div> <div>436-</div> <div> <div>CONDITIONS, IF ANY, WHICH
GAVE RISE TO IMMEDIATE
CAUSE (a), stating the
underlying cause last.</div> <div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> <div>(b) Cerebrovascular accident with right hemiparesis</div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> <div>(c)</div> </div> </div> </div> <td colspan="2">years</td> | | | | | | | | years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Chronic brain syndrome; Diabetes mellitus; Convulsive disorder. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 19 , 19 66 , to August 12 , 19 79 , that <input checked="" type="checkbox"/> (we) lost
saw the deceased alive on August 12 , 19 79 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated
above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
James W. Wills, M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
August 12, 1979 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
James W. Wills, M.D. | | | | 22e. ADDRESS
Glenn Dale Hospital
Glenn Dale, Maryland 20769 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
8/16/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Lincoln Memorial Cemetery, Suitland, Maryland | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
ALEXANDER S. POPE FUNERAL HOME
Alex S. Pope 2617 E. Howard St. | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 20 1979 | | | | | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | | | | | | | | |

BP



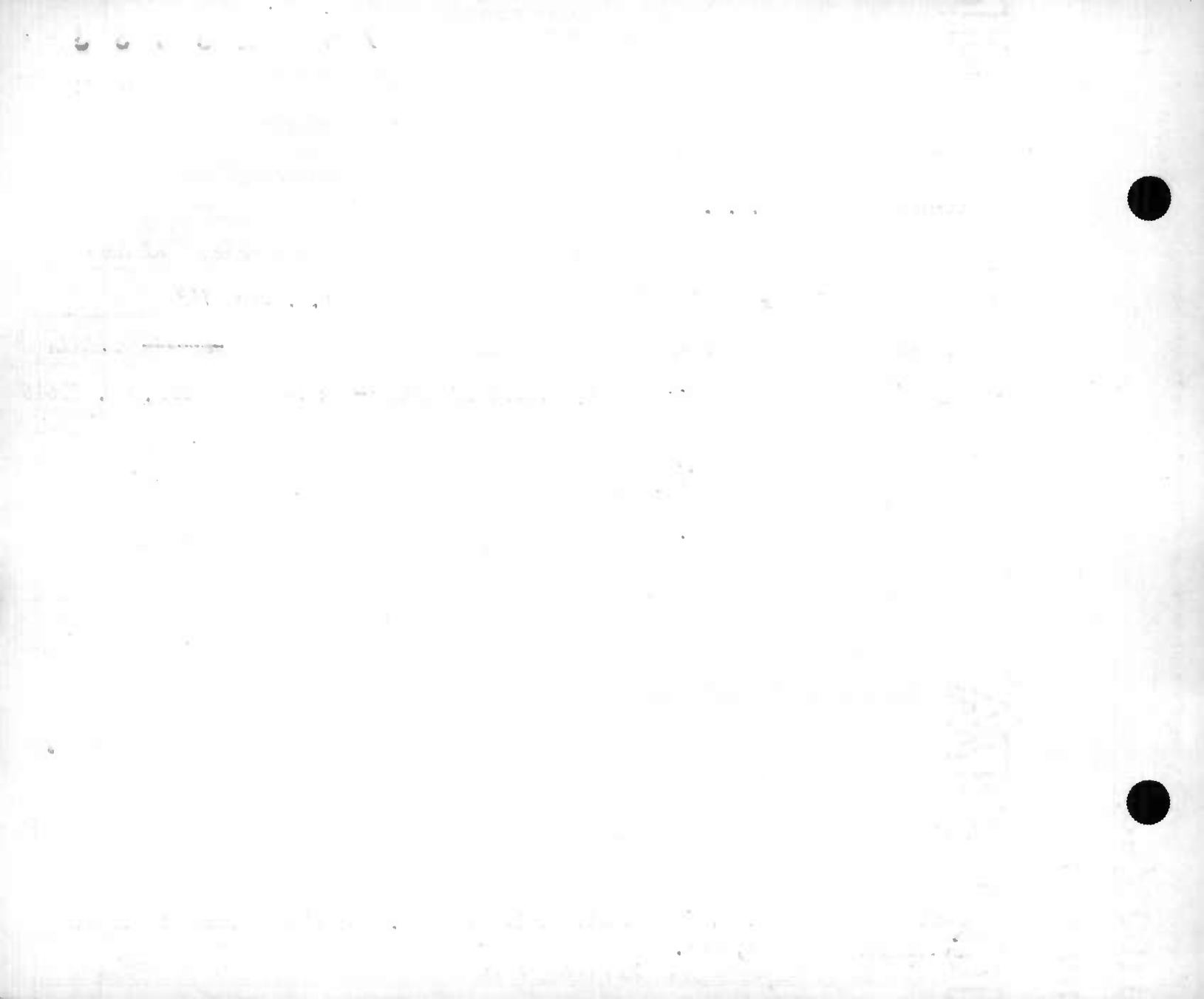
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|---|---|--|-------------------------------------|
| 1. FOR
STATE
REGISTRAR | | | REG. NO. 9 20833 | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST MIDDLE LAST
RUTH Margaret SWANN | | | 2b. DATE OF DEATH MONTH DAY YEAR
08 15 79 | | | 2c. HOUR
4:00 PM |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR
02 04 05 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS | | 7. IF UNDER 1 YEAR IF UNDER 24 HRS
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince Georges County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Clinton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)
SOUTHERN MARYLAND HOSPITAL CENTER | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Home maker | | 12b. KIND OF BUSINESS OR INDUSTRY
at home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
Charles | | 13c. CITY OR TOWN
La Plata | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
P.O. Box 143 |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Robert Welch | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE
Hanna Franklin | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
219-58-7867 | | 17. INFORMANT ADDRESS
Irene Pilkerton-Box 143 La Plata, MD. 20646 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 5990 Cerebral Vascular Accident
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Blood Infection - Myocardial
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Hours | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-10-1979 to 8-15-1979, that (I) (we) lost saw the deceased alive on 8-15-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22a. SIGNATURE
R. M. Brown, M.D. | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
8/16/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
R. M. BROWN | | | 22e. ADDRESS
4235 28th Ave Md 20031 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
8/18/1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Christ Episcopal Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Wayside Charles Maryland | | |
| 24. FUNERAL DIRECTOR
Richard Funeral Home, Inc. | | | ADDRESS
211 St. Marys Ave. | | 25a. DATE REC'D. BY REGISTRAR
AUG 22 1979 | | 25b. REGISTRAR'S SIGNATURE
Dorothy McCready | | |

BP



| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|
| 1- FOR
STATE
REGISTRAR | | REG. NO. 79 20834 | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Walter Anthony Thorne | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
August 10, 1979 | | 2b. HOUR
12:40 PM | |
| 3 SEX
Male | | 4 RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
September 9, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince George's MD. | | | |
| 10. CITY OR TOWN OF DEATH
Riverdale | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Eugene Leland Memorial Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired-Book Store U. of Md. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Maryland | | 13b. COUNTY
Prince Geo. | | 13c. CITY OR TOWN
Riverdale | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
4605 East West Highway | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Walter E. Thorne | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Augusta McCarthy | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
219-12-3036 | | 17. INFORMANT ADDRESS
Kathleen Riley-Cousin | | 822 Roger Williams Ave.
East Providence, R.I. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Massive bleeding from duodenal ulcer</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Sudden | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Diabetes mellitus and diabetic vascular disease</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>April 1</u> , 19 <u>76</u> , to <u>August 10</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>August 10</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Carl J. Houmann</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
August 10, 1979 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Carl J. Houmann, M. D. | | | | 22e. ADDRESS
4404 Queensbury Road, Riverdale, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
8/14/1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Washington National Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY
Suitland, Prince Geo. Maryland | | | |
| 24. FUNERAL DIRECTOR
Aronson Funeral Home, Inc. | | | | 24a. ADDRESS
2411 St. Mary's Ave.
Plata, Maryland | | 25a. DATE REC'D. BY REGISTRAR
AUG 22 1979 | | 25b. REGISTRAR'S SIGNATURE
Porter, McQuerry | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
1/VR A15 ME (5)
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20835

| | | | | | |
|--|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 3. SEX | | 4. RACE | |
| Petrus J. Tiebosch | | Male | | White | |
| 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | 7. CITIZEN OF WHAT COUNTRY? | |
| June 27, 1957 | | 22 YRS. | | U.S.A. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 8. MARRIED | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Zeelst, Netherlands | | WIDOWED | | Prince George's County, MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Laurel | | Greater Laurel Beltsville Hospital | | Parts Man-Mercedes Auto | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| Maryland | | Anne Arundel | | Laurel | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. SOCIAL SECURITY NO. | |
| Petrus J. Tiebosch | | Johanna DeSteur | | 215 72 1341 | |
| 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Robert S. Tiebosch Same as #13 | | PART 1 DEATH WAS CAUSED BY: | | | |
| | | IMMEDIATE CAUSE (a) | | | |
| | | Inhalation of smoke and flame | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | (b) | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | (c) | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| | | ? P.M. 8 17 1979 | | Subject caught in house fire | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| | | home | | 15 S. Gail St., Laurel, Prince George's, Md. | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| Virginia L. Dolan | | Assistant | | 8/18/79 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | |
| Virginia L. Dolan, M.D. | | 111 Penn Street | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 20 AUG 79 | | Maryland Veterans Cem | |
| 24. FUNERAL DIRECTOR | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| NAME | | AUG 22 1979 | | Dorothy McCready | |
| 9013 Annapolis Rd. Lanham, Md. 20801 | | | | | |

3 2 0 0



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7 9 20836

| | | | | | | | |
|--|--|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) PEARL A. TILGHMAN | | | 2a. DATE OF DEATH
MONTH 8 DAY 9 YEAR 79 | | | 2b. HOUR
1 P.M. | |
| 3. SEX
FEMALE | | 4. RACE
BLACK | | 5. DATE OF BIRTH
MONTH 10 DAY 23 YEAR 95 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGE'S MD. | |
| 10. CITY OR TOWN OF DEATH
FORESTVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
REGENCY | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CUSTODIAL | |
| 12b. KIND OF BUSINESS OR INDUSTRY
U.S. GOVT. | | | | | | | |
| 13a. STATE
MD. | | | | 13b. COUNTY
PG. | | 13c. CITY OR TOWN
D. HEIGHTS | |
| 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET ADDRESS
2001 COUNTY ROAD | | | |
| 14. FATHER'S NAME
FIRST Michael MIDDLE Tilghman LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST MAGGIE MIDDLE TILGHMAN LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
579-24-6715-T | | 17. INFORMANT
ADDRESS DISTRICT HEIGHTS, MD.
MR. RUSSELL A. DAVAGE/2001 COUNTY ROAD, | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CHF
586-
DUE TO, OR AS A CONSEQUENCE OF
(b) UREMIA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 DAYS |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-18 , 19 79 , to 8-9 , 19 79 , that (I) (we) last saw the deceased alive on 8-8 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Andre Laz MD | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
8-9-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ANDRE LAZ MD | | | | 22e. ADDRESS
9401 INDIAN HEAD HWY | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
AUG. 16, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
RESURRECTION CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
CLINTON PG MARYLAND | |
| 24. FUNERAL DIRECTOR
HOLLINS FUNERAL HOME, INC. 4399 HUNT PLACE, N. E. | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 15 1979 | | 25b. REGISTRAR'S SIGNATURE
Anthony McBrady | |

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UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

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Items #18a-22a F41m G536 10/11/79 STATE OF MARYLAND
 1- FOR item 18a G536 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 REGISTRAR 10/24/79 dad MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20837
 REG. NO.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---------|--|--|--|-------------------|--|--|--|---|--|---|--|------|--|---|--|----|--|----|--|----------|--|-------------------------------|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN
OF DEATH | | <input checked="" type="checkbox"/> MONTH | | DAY | | YEAR | | 2b. HOUR | | | | | | | | | | | | | | | |
| Nicole | | LASHAWN | | TOLLIVER | | | | 8 | | 29 | | 19 | | 79 | | M | | | | | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE
PRONOUNCED
DEAD | | 8 | | 29 | | 19 | | 79 | | 2d. HOUR | | | | | | | | | |
| female | | black | | March 22, 1978 | | 1 YRS. 04 | | MONTHS | | DAYS | | HOURS | | MIN. | | 8 | | 29 | | 19 | | 79 | | 1:28 p.m. | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | |
| MARYLAND | | | | UNITED STATES | | | | | | | | Prince George County MD. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | |
| Cheverly | | | | Prince George General Hospital | | | | | | | | none | | | | n/a | | | | | | | | | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | 13a. CITY OR TOWN | | | | | | | | 13d. INSIDE CITY LIMITS? | | | | | | | | 13e. STREET ADDRESS | | | | | | | |
| 13a. STATE | | | | | | | | 13b. COUNTY | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | 1125 CAPITOL VIEW DRIVE #1323 | | | | | | | |
| MARYLAND | | | | | | | | P. G. | | | | | | | | LANDOVER | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | |
| EUGENE | | | | | | | | HOUSTON | | | | | | | | ELIZABETH | | | | | | | | TOLLIVER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | 17. INFORMANT # 1323 | | | | | | | | VIEW DRIVE LANDOVER, MD. | | | | | | | |
| NO | | | | | | | | NONE | | | | | | | | BERNARD TOLLIVER / GRANDFATHER / 1125 CAPITOL | | | | | | | | | | | | | | | |

| | | | |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 1 DEATH WAS CAUSED BY: | | | |
| IMMEDIATE CAUSE (a) - Sudden infant death syndrome Pneumonitis & Bronchiolitis | | | |
| 7701 | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. | | | |
| (b) | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (c) | | | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| | | | | | |
|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR
CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |

| | | | |
|---|--|--|--|
| 22a. I certify that I took charge of the remains described above, held on | | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | |
| death resulted from: | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| ACTUAL SIGNATURE <i>Margarita A. Korell</i> | | TITLE (SPECIFY) Assistant | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | DATE SIGNED 8/31/79 | |
| ADDRESS 111 Penn Street, Balto., MD 21201 | | | |

| | | | | | | | |
|--|--|---------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| BURIAL | | Sept. 4, 1979 | | HARMONY CEMETERY | | SEP LANDOVER PG MARYLAND | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE OF DEATH BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | | |
| ROLLINS FUNERAL HOME, INC. 4339 HUNT PL. N. E. | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IN EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1065

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 20838 | |
|---|----------------------|---|--|--|---|---|-------------------|---|-------------------|--|-------------------|
| 1. DECEASED NAME (TYPE OR PRINT) John Edward TUNSTALL | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 8-1 1979 | 2b. HOUR M |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH 8 DAY 5 YEAR 24 | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | IF UNDER 1 YR. MONTHS 5 DAYS 4 | IF UNDER 24 HRS. HOURS 5 MIN 4 | 2c. DATE PRONOUNCED DEAD 8-1 1979 | 2d. HOUR P | 2e. HOUR M | 2f. HOUR M | 2g. HOUR M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Prince George's Gen'l Hosp | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Reporter | | 12b. USUAL OCCUPATION (TYPE OF WORK OR INDUSTRY) Utilities | | | |
| 13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Pr. Geo's | | 13c. CITY OR TOWN Mt. Rainier | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 4509 Russell Avenue | | | |
| 14. FATHER'S NAME FIRST James MIDDLE William LAST Tunstall | | | | | 15. MOTHER'S MAIDEN NAME FIRST Rylma MIDDLE Alice LAST Wistner | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO. WWII | | 16c. SOCIAL SECURITY NO. 579-18-1987 | | 17. INFORMANT ADDRESS Margaret F. Tunstall (wife) same as 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
9530 IMMEDIATE CAUSE (a) Asphyxia by hanging
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR 8-1 MONTH 19 DAY 79 P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) hanged self | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home | | 21f. LOCATION 4509 Russell Avenue, Mt. Rainier, Pr. George's CITY OR TOWN Mt. Rainier COUNTY Pr. George's STATE Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Augusta P. Priddy | | | | TITLE (SPECIFY) MD | | | | MEDICAL EXAMINER | | DATE SIGNED 8-2-79 | |
| EXAMINER'S NAME (TYPE OR PRINT) Augusta P. Priddy | | | | ADDRESS 5009 Rayburn Ct. Camp Springs | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 8/6/1979 | | 23c. NAME OF CEMETERY OR CREMATORY Maryland Vets Cem | | | | 23d. LOCATION CITY OR TOWN Cheltenham COUNTY Pr. Geo's STATE Md. | |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons, PA | | | | ADDRESS Hyattsville, Md. | | | | 25a. DATE REC'D. BY REGISTRAR AUG 6 1979 | | 25b. REGISTRAR'S SIGNATURE History McCreedy | |



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

10

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

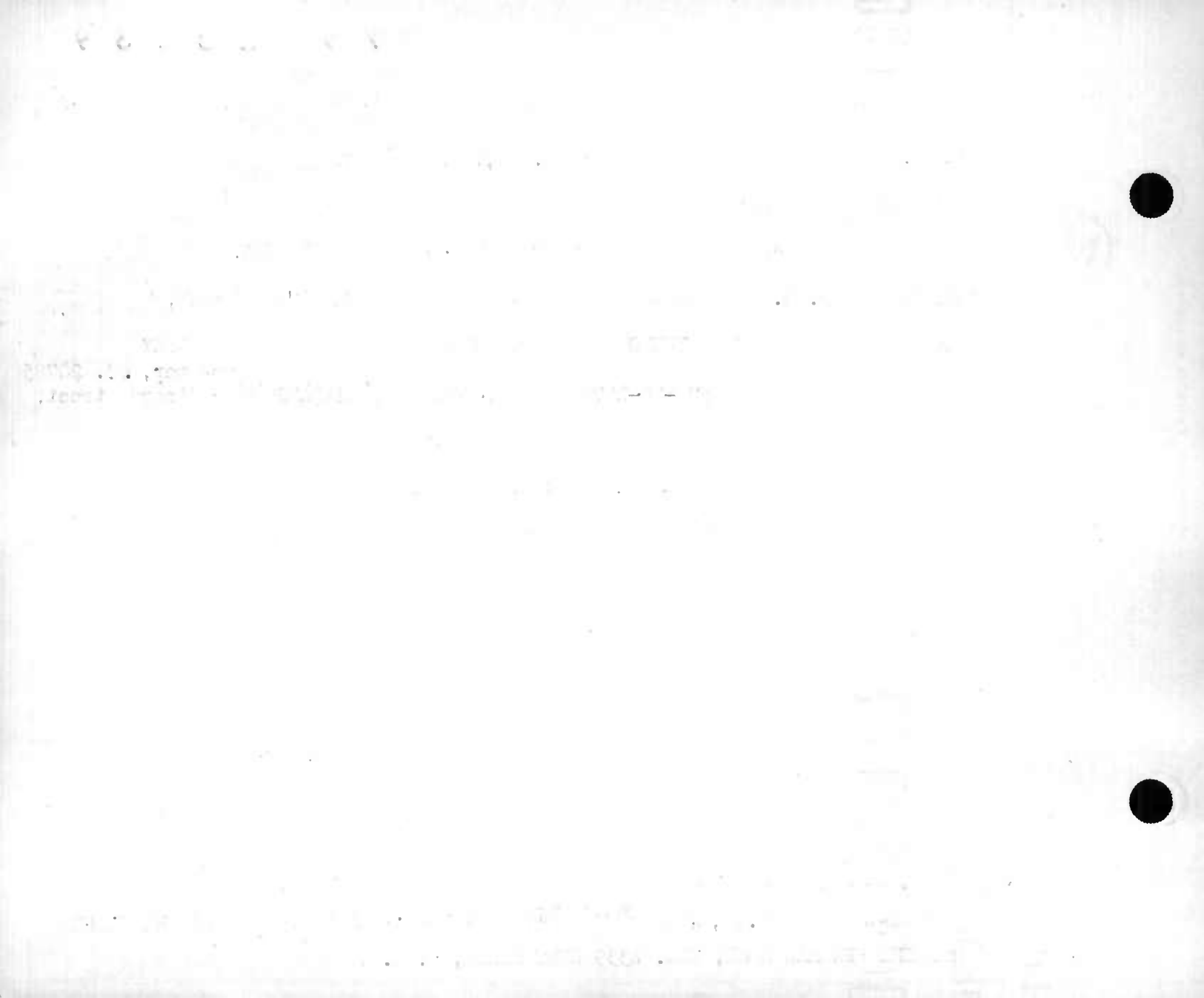
7 9 20839

REG. NO.

| | | | | | | | | | | | |
|--|--|--|---|--|--|--|--|---|---|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
Lottie L. Turner | | | 2a DATE OF DEATH
MONTH DAY YEAR
August 12, 1979 | | | 2b HOUR
8:50a M | | | | | |
| 3 SEX
FEMALE | | 4 RACE
BLACK | | 5 DATE OF BIRTH
MONTH DAY YEAR
SEPT. 24, 1904 | | 6 AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | | 7 IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Prince George's MD. | | | | | |
| 10 CITY OR TOWN OF DEATH
Lanham | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Doctors' Hospital of Prince Geo. | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b KIND OF BUSINESS OR INDUSTRY
N/A | | | |
| 13a STATE
MARYLAND | | | 13b COUNTY
P. G. | | 13c CITY OR TOWN
MARLBORO | | 13d INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS
9319 D'ARCY ROAD, | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
ROBERT U YOUNG | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
AGNES MEDLEY | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | 16b SOCIAL SECURITY NO.
578-26-1279 | |
| 17 INFORMANT
LOUISE JOHNSON/DAUGHTER/8609 Girard Street, | | | ADDRESS Landover, Md. 20785 | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio respiratory Failure</u>
496-
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.
(b) <u>Chronic Obstructive Pulmonary Disease</u>
(c) <u>Cerebrovascular Accident</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from <u>4/23/79</u> , 19_____, to <u>8/12/79</u> , 19_____, that (I) (we) last saw the deceased alive on <u>8/12/79</u> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE
<u>Rafael C. Lee</u> | | | DEGREE
M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED
8-12-79 | | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
Rafael C. Lee, M.D.
9410 Brandywine Road. | | | 22e ADDRESS
Clinton Md 20735 | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b DATE
AUG.17,1979 | | 23c NAME OF CEMETERY OR CREMATORY
FORT LINCOLN CEMETERY | | 23d LOCATION
CITY OR TOWN COUNTY STATE
BRENTWOOD PG MARYLAND | | | | |
| 24 FUNERAL DIRECTOR
ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. | | | | | 25a DATE REC'D. BY REGISTRAR
AUG 15 1979 | | 25b REGISTRAR'S SIGNATURE
<u>History McBrady</u> | | | | |

MEDICAL CERTIFICATION

29



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

9 20840

| | | | | | | | |
|--|--|---|---|--|-----------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| MARIE C. TYLOR | | 08-20-79 | | 6:30 AM | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| FEMALE | WHITE | NOV 17, 1914 | 64 YRS. | | MONTHS | DAYS | HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| WASHINGTON, D. C. | U.S.A. | | PRINCE GEORGE'S MD. | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| CHEVERLY | PRINCE GEORGE'S GENERAL HOSPITAL | | ADMINISTRATIVE | | ASST. GOVT. | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | |
| MARYLAND | | PRINCE GEORGES | ADELPHI | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 1836 METZEROTT ROAD | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | ADDRESS | | | |
| GEORGE L. TYLOR | | ANNA STEINDLE | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| NO | | 579-32-5627 | | MARGARET KEMP SAME AS 13 SISTER | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA
1749
DUE TO, OR AS A CONSEQUENCE OF
(b) CARCINOMA BREAST
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/20/79, 1979, to 8/21/79, 1979, that (I) (we) last saw the deceased alive on 8/20/79, 1979, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
S. Punja (PUNJA) | | 22c. DATE SIGNED
8/21/79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| Francis J. Collins | | 1687 Earlen Ave. MD 20018 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| BURIAL | | 8/23/79 | | MT. OLIVET CEMETERY | | WASHINGTON, D. C. | |
| 24. FUNERAL DIRECTOR
NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Francis J. Collins | | AUG 28 1979 | | [Signature] | | | |
| 500 UNIV. BLVD., W. SILVER SPRING, MD. 20901 | | | | | | | |

MEDICAL CERTIFICATION

SEC UNIV. BLVD. W. ST. LUT. SPRING, MO. 63061
 BUREAU FRANCIS J. COLLINS
 1/23/72
 MR. OLIVET CARMON
 WASHINGTON, D. C.

GEORGE

TYLOR

ANNA

STEINIE

NO 570-26-2627 MARGARET KEMP SALT AS 13 SISTER

MARYLAND

PRINCE GEORGE'S ADELPHI

1838 HETTEROTT ROAD

CHEVERLY

PRINCE GEORGE'S GENERAL HOSPITAL

ADMINISTRATIVE ASST.

WASHINGTON, D.C. U.S.A.

PRINCE GEORGE'S

FEMALE

WHITE

NOV 17, 1914

84

WAIR

D.

TYLOR

03-24-72

01-20-72



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20841
 REG. NO.

| | | | | | | | | | | | | |
|--|--------|---|--|---|--|--|--|----------------------------|-----------------------------------|--|--|---------|
| 1- STATE REGISTRAR | | 2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR | | | | | | | | | | 2b HOUR |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2c DATE PRONOUNCED DEAD | | MONTH DAY YEAR | | 2d HOUR |
| Millard Fillmore Ulrich, Jr. | | | | | | | | 8 10 1979 | | | | 7:45 PM |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | | | |
| Male | White | Feb 11, 1942 | | 37 YRS. | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Washington, D.C. | | U.S.A. | | | | Prince George's County, MD | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Lanham | | Doctors Hospital | | | | never worked | | | n/a | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | |
| Maryland | | Pr. Geo. | | Bowie | | | | 13317 Yarland Lane | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | |
| Millard Fillmore Ulrich, Sr. | | | | | | Mary Lally | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | |
| no | | | | n/a | | 579 62 6454 Mary Ulrich Same as # 13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Drowning</u> | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | |
| (b) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR XXX MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 6:10 P.M. 8 10 1979 | | | | | | subject drowned in pool | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| | | | | pool | | 12408 Yorktown Dr. Bowie | | P.G. | | MD | | |
| 22. I certify that I took charge of the remains described above, held or disposed of them, and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) | | | | DATE SIGNED | | | | |
| <i>Thomas D. Smith</i> | | | | M.D. Deputy Chief | | | | 8/14/79 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | |
| Thomas D. Smith, M.D. | | | | 111 Penn St Balto., MD | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | |
| Burial | | 16 AUG 79 | | Fort Lincoln Cemetery | | Brentwood, P.G., Md. | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Robert G. Beall Funeral Home | | | | | | AUG 22 1979 | | <i>Patricia McCreedy</i> | | | | |
| 9013 Annapolis Rd. Lanham, Md. 20801 | | | | | | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

14002

14002

14002

14002



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner, must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 7 9 20842 | |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1 - FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Margaret L. Vance | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
August 29 79 | | 2b. HOUR
4:55a _M | | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 7, 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
71 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 7. IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U S A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince George's MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Riverdale | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Eugene Leland Memorial | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE
Md | | 13b. COUNTY
Pro Georges | | 13c. CITY OR TOWN
Seabrook | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
9745 Good Luck Road | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Newton Whitt | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Flora Mae Burgess | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
235 98 3323M | | 17. INFORMANT
ADDRESS
Addie L Shaw Seabrook Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Septicemia</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>urinary tract infection</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Rheumatoid arthritis</u>
7140
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Acute Renal Failure</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>August 15</u> , 19 <u>79</u> , to <u>August 29</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>August 28</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Abraham Dabela</u>
DEGREE | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
8-29-79 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Abraham Dabela, M.D. | | | | | | 22e. ADDRESS
4404 Queensbury Rd., Riverdale, Md. 20840 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Aug 31, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Pro Georges Md. | | | | | |
| 24. FUNERAL DIRECTOR
NAME
F. Gasch's Sons P A Hyattsville, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
SEP 4 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>Hester McCreedy</u> | | | |

242274





Items #9, 13e, 14 Film G535 9/28/79 r STATE OF MARYLAND Item 18a. Film G536 10-11-79 as
 1 - FOR
 STATE
 REGISTRAR
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH
 REG. NO. 20843

| | | | | | | | | | |
|---|--|--|---|--|--|--|--|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
CHARLES R. VANDERCOOK | | | 2a. DATE OF DEATH
MONTH DAY YEAR
8 31 79 | | | 2b. HOUR
10:00 P | | | |
| 3 SEX
Male | | 4 RACE
white | | 5 DATE OF BIRTH
MONTH DAY YEAR
Oct 28, 1912 | | 6 AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | 7 IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Ohio | | 7b. CITIZEN OF WHAT COUNTRY?
U S A | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Pro. Georges County MD. | | | |
| 10 CITY OR TOWN OF DEATH
RIVERDALE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LELAND MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Engineering technician NASA | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md | | 13b. COUNTY
Pro Georges | | 13c. CITY OR TOWN
Riverdale | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5616 67th Ave.
7th ave., | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Reuben
Ruben VanDercook | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Hattie Miller | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
216 44 3112 | | 17 INFORMANT
Elizabeth W VanDercook | | ADDRESS
Riverdale, Md. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the prostate gland
DUE TO, OR AS A CONSEQUENCE OF
(b)
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
185- | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 8-ys. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug- 8-31 19 78 to Aug 31 19 79 , that (I) (we) lost
saw the deceased alive on above, (I) (we) (did) (did not) sign the burial after death. (and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | | | |
| 22b. SIGNATURE
Kai-Yin Yew | | | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
9-1-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Kai-Yin Yew MD | | | | 22e. ADDRESS
6225 Belmont Rd #460 Hyattsville, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Sept 6, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
Wheatland Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Wheatland Platte Wyoming | | | |
| 24 FUNERAL DIRECTOR
NAME
F. Gasch's Sons | | | | ADDRESS
P A Hyattsville, Md. | | 25a. DATE REC'D. BY REGISTRAR
SEP 5 1979 | | 25b. REGISTRAR'S SIGNATURE
Dorothy McCreedy | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|---|---|---|--|---|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. 9 20844 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
PARTHENIA T. VAUGHAN | | | 2a. DATE OF DEATH
AUGUST 27 1979 | | | 2b. HOUR
5:00P M | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
March 26 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince George's MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Lanham | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Doctors' Hospital of Prince Geo. Co. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
House wife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | |
| 13a. STATE
Md. | | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
Hyattsville | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
6814 Parkwood St. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas Jefferson Teaster | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Cassie Early | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
245-76-3709 | | 17. INFORMANT ADDRESS
Ronald C Cayton, Same as # 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1 DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <u>MASSIVE PULMONARY EMBOLISM, BILATERAL WITH</u>
<u>4442</u>
DUE TO, OR AS A CONSEQUENCE OF <u>THROMBI IN RIGHT VENTRICLE.</u>
(b) _____
DUE TO, OR AS A CONSEQUENCE OF <u>VENOUS THROMBI, LOWER EXTREMITIES.</u>
(c) _____
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (this hospital) attended the deceased from <u>August 19</u> , 19 <u>79</u> , to <u>August 27</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>August 27</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>M. A. Nandedkar</u> | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. A. Nandedkar, M.D., Pathologist | | | 22e. ADDRESS
Doctors' Hospital of Pr. Geo. Co.
8118 Good Luck Road, Lanham, Md. 20801 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
8-30-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Ahoskie Cemetery | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Ahoskie, Hertford, N.C. | | |
| 24. FUNERAL DIRECTOR
NAME
F. Gasch's Sons, P.A. 4739 Balt. Ave. Hyattsville, Md. | | | 25a. DATE REC'D. BY REGISTRAR
APR 3 1979 | | | 25b. REGISTRAR'S SIGNATURE
<u>Henry McChesney</u> | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|--|---|---|--|---|------------------------------------|--|---|-----------------------|
| 1. FOR STATE REGISTRAR | | | | | 7 9 2 0 8 4 5
REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
VIRGIL LOUIS VERMEIRE | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
AUGUST 21 1979 | | | | | 2b. HOUR
0900 A.M. |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
AUGUST 31 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY)
54 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
ILLINOIS | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGES COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
ANDREWS AIR FORCE BASE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
MALCOLM GROW USAF MEDICAL CENTER | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
PILOT | | 12b. KIND OF BUSINESS OR INDUSTRY
USAF | | |
| 13a. STATE
MARYLAND | | | | | 13b. COUNTY
PRINCE GEORGES CAMP SPRINGS | | 13c. CITY OR TOWN
CLARIDGE ROAD | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
JULUIS NONE VERMEIRE | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MARY NONE VANDEVOORDE | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
JUNE 1923 357-03-5014 | | 17. INFORMANT ADDRESS
STEVEN PETER VERMEIRE/SON
2815 31st SE WASHINGTON D.C. 20020 | | | | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) <i>cardiac dysrhythmia</i>
410- } DUE TO, OR AS A CONSEQUENCE OF
b) <i>acute myocardial infarction</i>
c) <i>hypertension, ASCVD</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>Aspiration pneumonia is probable</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Glenn C. Cockerham</i> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
21 Aug 79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GLENN C. COCKERHAM, CAPT, USAF, MC | | | | 22e. ADDRESS
MALCOLM GROW USAF MEDICAL CENTER
ANDREWS AIR FORCE BASE, MARYLAND, 20331 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
8/25/79 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Anthony's Cath. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Atkinson Henry Ill. | | | | |
| 24. FUNERAL DIRECTOR OR NAME
Lee Funeral Home Inc. | | | | 24b. ADDRESS
6633 Old Alexander Ferry Rd. Clinton, Md. | | 25a. DATE REC'D. BY REGISTRAR
AUG 27 1979 | | 25b. REGISTRAR'S SIGNATURE | | |



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9

2 0 8 4 6

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | |
|--|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) CARL G. VOGEL | | | 2a. DATE OF DEATH
MONTH 8 DAY 4 YEAR 79 | | 2b. HOUR
5¹⁰ PM |
| 3 SEX
MALE | 4 RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH 8 DAY 21 YEAR 20 | | 6 AGE (IN YEARS LAST BIRTHDAY)
58 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGE'S MD | |
| 10. CITY OR TOWN OF DEATH
CLINTON | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
50 MP HOSPITAL CENTER | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Pressman | | 12b. KIND OF BUSINESS OR INDUSTRY
Newspaper |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. CITY OR TOWN Pr. George's 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13d. STREET ADDRESS
3845 ST. BARNABAS RD. | | |
| 14. FATHER'S NAME
FIRST Valentine MIDDLE Vogel LAST Vogel | | 15. MOTHER'S MAIDEN NAME
FIRST Anna MIDDLE April LAST April | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) yes | | 16b. SOCIAL SECURITY NO.
201-07-8135 | | 17. INFORMANT
Catherine A Vogel ADDRESS 3845 St. Barnabas Rd Silver Hill, Md | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) metastatic adenocarcinoma of unknown primary to the liver
1991
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 mos. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION
9/9 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 79 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from May , 19 79 , to August , 19 79 , that (I) (we) lost
saw the deceased alive on 8-4 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Kai-Yin Young, MD | | DEGREE | | 22c. DATE SIGNED
8-5-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Kai-Yin Young, MD | | 22e. ADDRESS
6521 Belcrest Rd #460 Hyattsville MD 20782 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
8/7/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Resurrection Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Clinton Pr. George Md. | | 24. FUNERAL DIRECTOR
NAME George P. Kelas Funeral Home
6160 Oxon Hill Rd. Oxon Hill, MD | | | |
| 25a. DATE REC'D. BY REGISTRAR
AUG 07 1979 | | 25b. REGISTRAR'S SIGNATURE
Anthony McCreedy | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

U. S. 100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 7/77
(VR A 15 (4))

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE / 9 20847
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|--|--|---|---|---|----------------------------------|---|---|---------------------|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
EDWARD D. WAID, Sr. | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
08 14 79 | | | | | 2b. HOUR
1:22P M |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 16 1923 | | 6. AGE (IN YEARS LAST BIRTHDAY)
56 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGES MD. | | | | |
| 10. CITY OR TOWN OF DEATH
CHEVERLY. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PRINCE GEORGES GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Custodian - Warehouse | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | | | 13b. COUNTY
Calvert | | 13c. CITY OR TOWN
North Beach | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Russell Waid | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emma L. Conner | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
234-26-6815 | | 17. HOME ADDRESS
5813 Cherrywood Lane, Greenbelt,
Edward D. Waid, Jr.- Son Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio respiratory arrest
410-
DUE TO, OR AS A CONSEQUENCE OF
(b) possible Ac MI ~ Cardiac arrhythmias
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from August 5, 1979, to 8-14 1979, that (I) (we) last saw the deceased alive on 8-13 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
L. SATIN | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
8-15-79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
L. SATIN | | | | 22e. ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
8-18-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Wash. Natl. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland, P.G., Md. | | | | |
| 24. FUNERAL DIRECTOR
NAME
Robt E Wilhelm | | | | ADDRESS
4308 Suitland Rd., Suitland, Md. | | 25a. DATE REC'D BY REGISTRAR
AUG 21 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | |

BP

100-100000-100000

00 14 33 11234

WILD, W.

WARD

June 12, 1953

14122 020000

CHERRY, PRINCE GEORGE'S GENERAL HOSPITAL

General Hospital

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Item 8 6534 8/28/79 83

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

| | | | | | | | |
|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
JAMES chauncy WALKER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
07 27 79 | | | 2b. HOUR
P
4:45 M | |
| 3. SEX
male | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept. 24 1902 | 6. AGE (IN YEARS LAST BIRTHDAY)
76 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | 7b. CITIZEN OF WHAT COUNTRY?
United States | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGE'S COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
CHEVERLY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PRINCE GEORGE'S GENERAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING YRS.)
Postal clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
Gov't. | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
D.C. | | 13b. COUNTY
Washington | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
607-60th Place NE | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James F. Walker | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Rebecca Mathis | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | |
| 16a. SOCIAL SECURITY NO.
223-09-5842 | | 17. INFORMANT
Betty J. Walker-daughter | | 17a. ADDRESS
4410 7th Pl. NE
Washington, D.C. | | 17b. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
(b) Atherosclerotic Coronary Artery Disease
DUE TO, OR AS A CONSEQUENCE OF
(c) An aneurysm | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION
7/24/79 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Peripheral vascular disease | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/16/79 to 7/28/79, that (I) (we) last saw the deceased alive on 7/27/79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22a. SIGNATURE
M. Ali Khan | | DEGREE
M.D. | | 22b. DATE SIGNED
7/29/79 | | 22c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
M. ALI KHAN | | 22e. ADDRESS | | | | | |

MEDICAL CERTIFICATION

| | | | |
|---|--------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
Aug 1, 1979 | 23c. NAME OF CEMETERY OR CREMATORY
HARMONY Cem | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Landover PG MD |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Kallus Funeral Home Inc. 4339 Mt Pl. NE | | 25a. DATE REC'D. BY REGISTRAR
AUG 3 1979 | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

BP

DHMH-16 20M
(VRA 15, 4) 7/78

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | 7 9 2 0 8 4 9
REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST
Dorothy | | MIDDLE
Marie | | LAST
Watts | | 2b. DATE OF DEATH MONTH DAY YEAR
August 9, 1979 | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Oct 27, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS. | | 7a. HOUR
1:31A. M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
D. C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince George's MD. | | | |
| 10. CITY OR TOWN OF DEATH
Lanham | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Pr. Geo's Doctors Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
N A S A Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
US Gov't | |
| 13a. STATE
Maryland | | 13b. COUNTY
Pr. Geo's | | 13c. CITY OR TOWN
Riverdale | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
5617 61st Place | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Percy Norman | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Virginia Meade | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
578-24-3324 | | 17. INFORMANT ADDRESS
Vernon Watts (Husband) same as blk 13e | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>respiratory Arrest</u>
430- <u>430-</u> DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Cerebral edema</u>
(c) <u>Subarachnoid Hemorrhage</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>immediate</u>
<u>9d</u>
<u>10d</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/30</u> 19 <u>79</u> , to <u>8/9</u> 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>8/8</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>D. Granite MD</u> | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
Aug 9, 1979 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
D. Granite MD | | 22e. ADDRESS
115 Centerway Greenbelt, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
8/13/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood Pr. Geo's Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Francis Gasch's Sons, PA Hyattsville, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 14 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>Jeffrey McCready</u> | | | |

MEDICAL CERTIFICATION

29

66601

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 7/77
(VRA 15 (4))

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|
| FOR
1 - STATE
REGISTRAR | | REG. NO. 20850 | | | | | | | |
| 1 DECEASED NAME
(TYPE OR PRINT) George C. Wentzel | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 8 23 79 | | 2b. HOUR 7:10p M | |
| 3 SEX male | | 4 RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 4, 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 7b CITIZEN OF WHAT COUNTRY? U. S. A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Prince George's MD. | | | |
| 10. CITY OR TOWN OF DEATH Riverdale | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Leland Memorial Hospital | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Past President | | 12b. KIND OF BUSINESS OR INDUSTRY Realty Co. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE 13b COUNTY 13c CITY OR TOWN 13d INSIDE CITY LIMITS? 13e STREET ADDRESS
Wash., D. C. Wash D. C. Wash., D. C. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 6234 - 32nd Place, N. W. | | | | | | | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Nelson B. Wentzel | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tama M. Ziegler | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b SOCIAL SECURITY NO. 578-01-5659 | | 17 INFORMANT ADDRESS Robert N. Wentzel 6234 - 32nd Place, N. W. Washington, D. C. 20015 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) circulatory Failure
2041 } DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Lymphocytic Leukemia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a DATE OF OPERATION - | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-20 19 79 to 8-23 19 79, that (I) (we) lost the deceased alive on 8-23 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE A. Shamim MD | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 8-24-79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ahmad Shamim, M. D. | | | | 22e. ADDRESS Laurel, Md. 20810 200 Fort Meade Rd., Suite 9, Steward Towers | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 8-29-79 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Prince Georges, Md. | | | |
| 24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., N. W., Washington, D. C. | | | | 25a. DATE REC'D. BY REGISTRAR AUG 30 1979 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

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RECEIVED
FEB 10 1968
U.S. DEPARTMENT OF JUSTICE



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951 952 953 954 955 956 957 958 959 960

961 962 963 964 965 966 967 968 969 970

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Handwritten notes and signatures in the bottom section of the form, including a large signature and the date "FEB 10 1968".

1430 Wisconsin Ave., N.W., Washington, D.C. 20004
U.S. DEPARTMENT OF JUSTICE
FEB 10 1968

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

79

20851

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|--|---|---|---|---|---|--|------------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CATHERINE M. WETZEL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
F-14-79 | | | 2b. HOUR
4:50 PM | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
JUNE 5, 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN
86 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGES MD. | | | | |
| 10. CITY OR TOWN OF DEATH
HYATTSVILLE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
CARROLL MANOR NURSING CENTER | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
PRINCE GEO. | | 13c. CITY OR TOWN
HYATTSVILLE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
FRANCIS A. REILLY | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CATHERINE T. IN-LAW CASSIDY | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | |
| 16b. SOCIAL SECURITY NO.
577-62-0532 | | | 17. INFORMANT
AMY REILLY, 4000 MASS AVE., N.W., WASH., D.C. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
1749 IMMEDIATE CAUSE (a) Metastatic Car of breast
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) 40 years ago
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Diabetes | | | | | | | | | | |
| 19a. DATE OF OPERATION
8/17/79 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/15/79 to 8/14/79 , that (I) (we) last saw the deceased alive on 8/15/79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
J. M. Khatir | | | DEGREE | | | ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/>
PHYSICIAN DIRECTOR PHYSICIAN | | | 22c. DATE SIGNED
8/14/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
IBRAHIM M. KHATIR | | | 22e. ADDRESS
1525 Belcrest Road Hyattsville Md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
8/17/79 | | 23c. NAME OF CEMETERY OR CREMATORY
GATE OF HEAVEN | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
SILVER SPRING MONT MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
FRANCIS J. COLLINS | | | 25a. DATE REC'D. BY REGISTRAR
AUG 20 1979 | | | 25b. REGISTRAR'S SIGNATURE
H. J. McBrady | | | | |
| 26. ADDRESS
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901 | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

| | | | | | | | |
|-----------|----------------------|---|--------------------|-----------|---------------|----------------|-----|
| NO | 577-62-0021 | AMY TETLY, 4000 ARS AVE. N.W., WASH. D.C. | FRANCIS A. COLLINS | 2/17/79 | DATE OF BIRTH | STIVERS SPRING | MO. |
| FRANCIS | A. | WILLIAM | CATHERINE | ESTER | CASSIN | | |
| NEWLAND | PRINCE GEO. | HATTVILLE | 4922 LA SALLE ROAD | HATTVILLE | | | |
| HATTVILLE | CARROLL MAJOR WATSON | CENTER | HATTVILLE | | | | |
| VERMONT | U.S.A. | PRINCE GEORGE | | | | | |
| WHITE | JUNE 3, 1903 | | | | | | |

FRANCIS A. COLLINS
 2/17/79
 DATE OF BIRTH
 STIVERS SPRING
 MO.
 577-62-0021
 AMY TETLY, 4000 ARS AVE. N.W., WASH. D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked ar item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|---|---|--|---|---|
| 1. FOR
STATE
REGISTRAR | | 7 20852
REG. NO. | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
RAYMOND F. WHITEHAIR | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
08 12 79 | | | 2b. HOUR P
6:42 M | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
JULY 29, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGE'S COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PRINCE GEORGE'S GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOSPITAL ADM. | | 12b. KIND OF BUSINESS OR INDUSTRY
G.W. UNIV | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND 13b. COUNTY PRI. GEO 13c. CITY OR TOWN RIVERDALE | | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
6903 FURMAN PARKWAY | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
ALVA D. WHITEHAIR | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
ELIZABETH M. THOMPSON | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW II 214-10-5399 | | 17. INFORMANT ADDRESS
REBA F. WHITEHAIR SAME AS 13 WIFE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 410- ACUTE INFERIOR WALL MYOCARDIAL INFARCTION.
DUE TO, OR AS A CONSEQUENCE OF (b) CARDIOGENIC SHOCK.
DUE TO, OR AS A CONSEQUENCE OF (c) OLD ANTERIOR WALL MYOCARDIAL INFARCTION. | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
30 hours |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8. 11. 19 79, to 8. 12. 19 79, that (I) (we) lost saw the deceased alive on 8. 12. 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
VPSingh | | | | DEGREE
M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
8. 13. 79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
VIRENDER P. SINGH | | | | 22e. ADDRESS
3700. EAST WEST HIGHWAY. HYATTSVILLE MD. 20782 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | | 23b. DATE
8/16/79 | | 23c. NAME OF CEMETERY OR CREMATORY
MARYDALE CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
CUMBERLAND MARYLAND | | | |
| 24. FUNERAL DIRECTOR
NAME FRANCIS J. COLLINS ADDRESS
500 UNIV. BLVD. W. SILVER SPRING, MD. 20901 | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 15 1979 | | 25b. REGISTRAR'S SIGNATURE
Anthony A. Brady | | | |

MEDICAL CERTIFICATION

500 W. 1st St., St. Louis, Mo. 63101
 FRANCIS J. COLLINS

BURIAL 1/18/79 NARVALE CEMETERY CUMBERLAND MARYLAND

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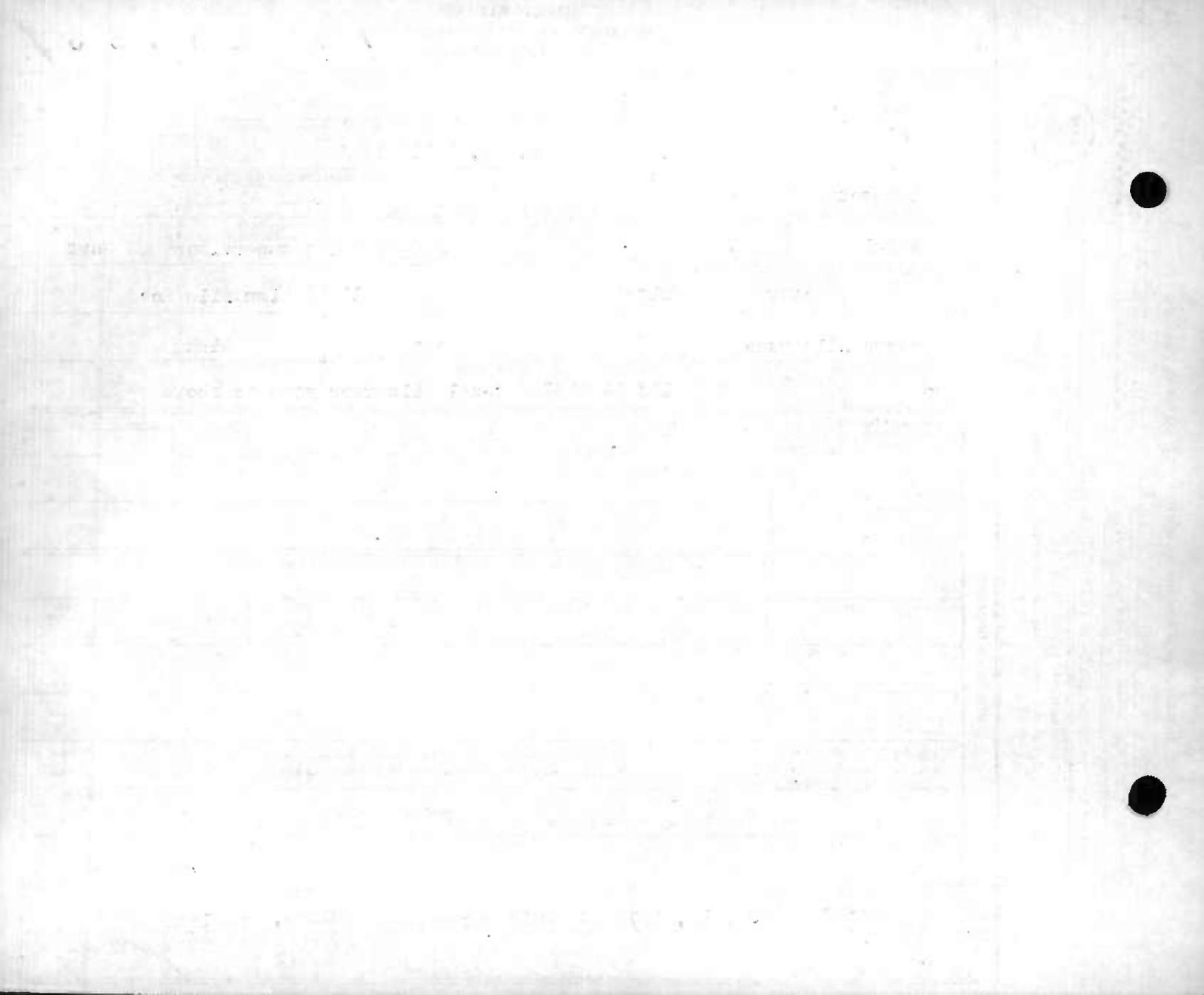
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|--|---|---|--|---|---|--|-----------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | 7 9 20853 | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
Gordon Wilkerson | | | | | 2a. DATE OF DEATH MONTH DAY YEAR
8/16/79 | | | | | 2b. HOUR
9:58 A.M. |
| 3. SEX
male | | 4. RACE
W | | 5. DATE OF BIRTH MONTH DAY YEAR
Dec. 12, 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Minnesota | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince George County MD. | | | | |
| 10. CITY OR TOWN OF DEATH
Laurel | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Greater Laurel Beltsville Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Paint supervisor | | 12b. KIND OF BUSINESS OR INDUSTRY
US Govt | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13a. STATE
Md | | 13b. COUNTY
Howard | | 13c. CITY OR TOWN
Fulton | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Herbert Wilkerson | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mona Sisk | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
no | | | 16b. SOCIAL SECURITY NO.
213 14 21874 | | 17. INFORMANT ADDRESS
Hazel Wilkerson same as above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>
2089
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u>
(c) <u>Leukemia</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| MEDICAL CERTIFICATION | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8-28</u> , 19 <u>77</u> , to <u>8-16</u> , 19 <u>78</u> , that (I) (we) lost saw the deceased alive on <u>8-16</u> , 19 <u>78</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Michael R. Poston | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
8/16/79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Michael R. Poston | | | | | 22e. ADDRESS
6109 Spring St, S. W. Washington, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
Aug. 19, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY
St Pauls Lutheran | | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Fulton, Maryland | | |
| 24. FUNERAL DIRECTOR NAME
[Signature] | | | | | 25a. DATE REC'D BY REGISTRAR
AUG 23 1979 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20854

| | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|---|--|--|--|----------------------|--|
| 1. FOR STATE REGISTRAR | | 2. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Fred Jay Williams, Jr. | | | | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR
8 20 19 79 | | 2b. HOUR
M | |
| 3. SEX
Male | | 4. RACE
Black | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 9, 1961 | | 6. AGE (IN YEARS)
LAST BIRTHDAY YRS.
18 | | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN
18 | | 7c. DATE PRONOUNCED DEAD
MONTH DAY YEAR
8 20 19 79 | | 7d. HOUR
1205P | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Chicago, Illinois | | | | 7b. CITIZEN OF WHAT COUNTRY?
United States | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince George's County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Cheverly | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Prince George's General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Student | | | | 12b. KIND OF BUSINESS OR INDUSTRY
SCHOOL | | | |
| 13a. STATE
CHICAGO | | | | 13b. COUNTY
<input checked="" type="checkbox"/> | | | | 13c. CITY OR TOWN
Illinois | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13e. STREET ADDRESS
7225 South Perry Avenue, | | | | 14. FATHER'S NAME
FIRST MIDDLE LAST
FRED J. WILLIAMS SR. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
BEATRICE NELSON | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | |
| 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT
MR. FRED J. WILLIAMS SR./7225 S. Perry St. | | | | ADDRESS Chicago, Illinois | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Drowning
9108
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR MONTH DAY YEAR
2 P.M. 8 19 19 79 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
subject drowned in swimming pool | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
swimming pool | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
1001 Enderberry Place, District Hgts, P.G., MD | | | | | | | |
| 22a. I certify that I took charge of the remains of the deceased and that the death resulted from
Natural causes <input type="checkbox"/> Poisoning <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
TITLE (SPECIFY)
Deputy Chief MEDICAL EXAMINER
DATE SIGNED 8/21/79 | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Thomas D. Smith</i> | | | | EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.
ADDRESS 111 Penn St. Balto., MD | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | | 23b. DATE
Aug. 25, 1979 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Restville Cemetery | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Alsip Illinois | | | |
| 24. FUNERAL DIRECTOR
NAME
ROLLINS FUNERAL HOME, INC. | | | | ADDRESS
4339 Hunt Pl. N. E. Wash. D.C. | | | | 25a. DATE REC'D. BY REGISTRAR
AUG 27 1979 | | | | 25b. REGISTRAR'S SIGNATURE
<i>Harry M. Brady</i> | | | |

June 9, 1964

Chicago, Illinois

Dear Sir:

Very truly yours,

Respectfully,

Respectfully,

WILLIAM J. WILSON
CHICAGO, ILLINOIS
WILLIAM J. WILSON, JR.
CHICAGO, ILLINOIS

WILLIAM J. WILSON, JR.

WILLIAM J. WILSON, JR.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M7/77
(VR A 15 (4))

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|--|
| 1. FOR
STATE
REGISTRAR | | 7 9 2 0 8 5 5
REG. NO. | | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
CAROLYN | | MIDDLE
V. | | LAST
YORK | | 2a. DATE OF DEATH
MONTH DAY YEAR
8 8 79 | | 2b. HOUR
6:24P
M |
| 3. SEX
FEMALE | | 4. RACE
CAUC. | | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 18 1944 | | 6. AGE (IN YEARS LAST BIRTHDAY)
35
YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Prince George
MD. | | | | |
| 10. CITY OR TOWN OF DEATH
RIVERDALE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
LELAND MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Acc't clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
Union | | |
| 13a. STATE
Va. | | 13b. COUNTY
Fairfax | | 13c. CITY OR TOWN
Springfield | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
6009 Hanover Ave. | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Gilbert R. Lewis | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Brown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
226-58-3549 | | 17. INFORMANT
ADDRESS
Teddy R. York 6009 Hanover Ave. Springfield Va. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 10a, 10b, and 10c)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Renal failure - Acidosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Ascites + pleural effusion</u>
(c) <u>Hodgkin's Disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION
- | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
- | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8-1-79</u> , 19 <u>79</u> , to <u>8-8</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>8-8</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>A. Shamim MD</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
8-8-79 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
A. SHAMIM | | | | 22e. ADDRESS
200 Ft. Meade Rd. Laurel, MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
burial | | 23b. DATE
8/11/79 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Wash. D.C. | | | | |
| 24. FUNERAL DIRECTOR
NAME
C. M. Grace | | | | ADDRESS
4510 Wilson Blvd. Arlington, Va. | | 25a. DATE REC'D. BY REGISTRAR
AUG 16 1979 | | 25b. REGISTRAR'S SIGNATURE
P. H. McCreedy | | |
| 26. NAME
Murphy FH | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. 9 20856 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
LEO W. YOUNG | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
08 06 79 | | | 2b. HOUR
1:15 AM | |
| 3. SEX
Male | | 4. RACE
Negro | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 17 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY)
66 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGE'S COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PRINCE GEORGE'S GENERAL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md | | 13b. COUNTY
P.G. | | 13c. CITY OR TOWN
Landover | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1123 Nalley Rd Apt. II4 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James W. Young | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | | | |
| 16a. SOCIAL SECURITY NO.
217*32-0746 | | 17. INFORMANT
Francis Young 8205 Grubb Road Silver Spring, Md Apt. 207 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Renal cell carcinoma</u>
1890
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 mos | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>79</u> , to <u>Aug</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>8-5</u> , 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Kai-Yin Yeung</u> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
8-6-79 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Kai-Yin Yeung</u> | | 22e. ADDRESS
6525 Belant Rd #460 Hyattsville MD 20882 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
8-9-79 | | 23c. NAME OF CEMETERY OR CREMATORY
Forest Hill Gardens | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Clinton P.G. Md | | | |
| 24. FUNERAL DIRECTOR
NAME
Martell Adams-RtI Box 185 Aquasco, Md. | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
AUG 17 1979 | | 25b. REGISTRAR'S SIGNATURE
<u>Richard A. Cundy</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 72 hours at the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4) 7/78

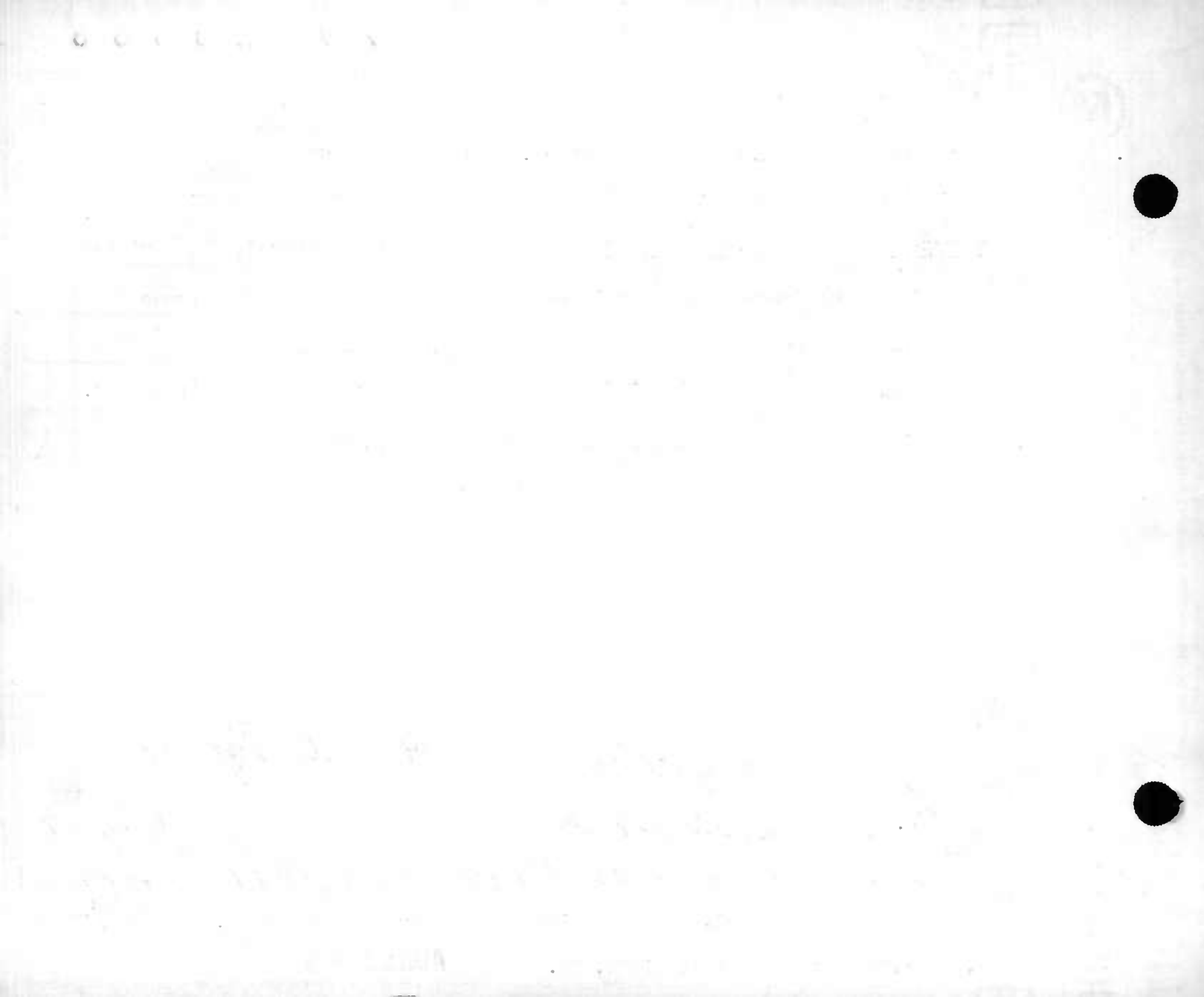
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

9 20858

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|--|--|--|---|--|--|--|--|---|--|--|
| 1 DECEASED NAME
(TYPE OR PRINT)
RUTH J. YOWELL | | | 2a DATE OF DEATH
MONTH DAY YEAR
08-16-79 | | | 2b HOUR
4:00AM | | | | |
| 3 SEX
female | | 4 RACE
white | | 5 DATE OF BIRTH
MONTH DAY YEAR
Jan 28, 1911 | | 6 AGE (IN YEARS LAST BIRTHDAY)
68 YRS | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | | 7b CITIZEN OF WHAT COUNTRY?
U S A | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
PRINCE GEORGES MD. | | | | |
| 10 CITY OR TOWN OF DEATH
CHEVERLY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
PRINCE GEORGES GENERAL HOSPITAL | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired | | 12b KIND OF BUSINESS OR INDUSTRY
Printer | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE
Md | | | 13b CITY OR TOWN
Pro Georges New Carrollton | | | 13c INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13d STREET ADDRESS
5297 85th Avenue | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Edwin C Jewell | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Laura V Havenner | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | 16b SOCIAL SECURITY NO
(IF YES, GIVE WAR OR DATES)
219 03 5269A | | | 17 INFORMANT
ADDRESS
Frances V Boss New Carrollton Md. | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EMBOLI LEFT LUNG
0389
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) SEPTICEMIA
(c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a.1 certify that (I) (this hospital) attended the deceased from 15 April 1979 to 16 May 1979, that (I) (we) last saw the deceased alive on 15 April 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. | | | | | | | | | | |
| 22b SIGNATURE
Thomas A. Bensinger MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
16 May 79 | | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)
Thomas A. Bensinger MD | | | | | | 22e ADDRESS
831 University Blvd P. Silsby MD | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b DATE
Aug 21, 1979 | | 23c NAME OF CEMETERY OR CREMATORY
Ft Lincoln Cemetery | | 23d LOCATION
CITY OR TOWN COUNTY
Brentwood, Pro Georges MD | | | |
| 24 FUNERAL DIRECTOR
NAME
F. Gasch's Sons P A | | | | | | 25a DATE REC'D. BY REGISTRAR
AUG 22 1979 | | 25b REGISTRAR'S SIGNATURE
Patrick McCreedy | | |
| ADDRESS
Hyattsville, Md. | | | | | | | | | | |



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7/11/79 CJH 08 F 8/2/10
TO HOSPITAL OR ATTENDING PHYSICIAN

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. Page 3 may be retained by the funeral director.

TO HOSPITAL OR ATTENDING PHYSICIAN: This certificate must be filed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

9 20859

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|--|---|---|---|---|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) MARGUERITE ZALESKI | | | 2a. DATE OF DEATH MONTH DAY YEAR AUG. 17 1979 | | | 2b. HOUR 11:58 AM | | | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH MONTH DAY YEAR Aug 21, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D C | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH PRINCE GEORGE COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH RIVERDALE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) EUGENE LELAND MEMORIAL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) Nurses Aid | | 12b. KIND OF BUSINESS OR INDUSTRY Hospital | | |
| 13a. STATE Md | | | 13b. COUNTY Pro Georges | | 13c. CITY OR TOWN Riverdale | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5710 66th ave | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 578 20 8157 | | 17. INFORMANT Leo Zaleski | | ADDRESS Riverdale, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Shock
DUE TO, OR AS A CONSEQUENCE OF
(b) Sepsis
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.
(c) Respiratory Failure, Pneumonia | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
Uremia, ASHD, CVA, Diabetes, HBP | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (the medical examiner) attended the deceased from 7/11/79 to 8/17/79 , that (I) (the medical examiner) saw the deceased alive on Aug 17 79 , and that in (my) (the medical examiner's) opinion death occurred on the date and hour and from the causes stated above, (I) (the medical examiner) (did) (not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Norton Elson | | | DEGREE MD | | | Consulting ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 8/17/79 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Norton Elson | | | 22e. ADDRESS 6525 Belcrest Rd. Hyattsville MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Aug 20, 1979 | | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pro Georges Md. | | | |
| 24. FUNERAL DIRECTOR NAME F. Gasch's Sons P A ADDRESS Hyattsville, Md | | | | | | 25a. DATE REC'D. BY REGISTRAR AUG 22 1979 25b. REGISTRAR'S SIGNATURE Pirkey McCready | | | | |

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